

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

06061

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
TOWN <u>25 Months</u>		TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Jolliffe's Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Unknown</u>	
3. NAME OF DECEASED (First) <u>Marguerite</u> (Middle) <u>-</u> (Last) <u>Aebersold</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>15</u> (Year) <u>19 51</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 25, 1871</u>
9. AGE last birthday <u>80</u> yrs.		10. If under 1 year <u>Months</u> <u>20</u> If under 24 hrs. <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Female Companion</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Jessie Hammerli</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Congestive Heart Failure

Antecedent cause(s)

(b)

Arteriosclerosis Hardened

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

7 days
yr.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/6/51, 19....., to 6/15/51, 19....., that I last saw the deceased alive on 6/14/51, 19....., and that death occurred at 2:50 p. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-18-51</u>	NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	LOCATION (City, town, or county) <u>Washington,</u>	(State) <u>D. C.</u>
DATE REC'D BY LOCAL REG. <u>6/18/51</u>	REGISTRAR'S SIGNATURE <u>Frances Colter</u>	24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>	ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 21 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06470

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>703 Maple Avenue</u>		STREET ADDRESS (If rural, give location) <u>703 Maple Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Florence</u>	(Middle) <u>E.</u>	(Last) <u>Baker</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-21-1873</u>
9. AGE last birthday <u>77</u> yrs.		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>30</u> (Year) <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Neelsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Acquilla Waters</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shaw</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Russell Baker-same as Item 2</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>CONGESTIVE HEART FAILURE</u>	<u>NINE WEEKS</u>
Antecedent cause(s)	(b) <u>PRE-RENAL AZOTEMIA</u>	<u>TEN DAYS</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>	<u>15 YEARS</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from APRIL 3, 1951, to JUNE 30, 1951, that I last saw the deceased alive on JUNE 30, 1951, and that death occurred at 2:25 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

<u>Gordon S. Raenburger M.D.</u>		<u>Rockville, Md.</u>		<u>6/30/51</u>
23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>7-2-1951</u>	<u>Rockville Union</u>	<u>Rockville</u>	<u>Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>7-2-51</u>	<u>Walter S. Calkins</u>	<u>Robert W. Humphrey</u>	<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 5 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06062

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY Alexandria	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Alexandria	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 904 Crescent Drive	
3. NAME OF DECEASED (First) Brenda (Middle) Jane (Last) BAILEY		4. DATE OF DEATH (Month) June (Day) 26 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH June 23, 1951
9. AGE last birthday 00 yrs. 00 months 03 days		10. If under 1 year: Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME James R. BAILEY		14. MOTHER'S MAIDEN NAME Ruth FULTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - -		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS Father: James R. BAILEY		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
762.0 Immediate cause (a) Atelectasis, pulmonary			
Antecedent cause(s) (b) 161a			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 23 , 19 51 , to June 26 , 19 51 , that I last saw the deceased alive on June 26 , 19 51 , and that death occurred at 4:50 A m., from the causes and on the date stated above.			
SIGNATURE L. W. Sederstrom		ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
DATE SIGNED June 26, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF June 26, 1951	
NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		LOCATION (City, town, or county) (State) Owensboro, Kentucky	
24. FUNERAL DIRECTOR Chevy-Chase Funeral Home, 5103 Wisconsin Avenue, N.W., Washington, D.C.			

206231314404

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 28 1951
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06063

223

Reg. Dist. No. 278

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Genmantown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Genmantown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>ELDER</u>	(Last) <u>Barnes</u>
6. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF DEATH <u>June 12 1957</u>
9. AGE last birthday <u>68</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	9. AGE last birthday <u>68</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Joe Barnes</u>	
14. MOTHER'S MAIDEN NAME <u>Honey Cheios</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u>10-408</u>		17. INFORMANT AND ADDRESS	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Apoplexy

Antecedent cause(s)

(b) Hypertensive cardiovascular disease

(c) stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 4, 1957, to June 1, 1957, that I last saw the deceased

alive on June 1, 1957, and that death occurred at 10:40 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 411

RECEIVED
JUN 19 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06064

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 27 East Street	
3. NAME OF DECEASED (Type or Print) Gaetano (First) (none) (Middle) BARRELLA (Last)		4. DATE OF DEATH June 27, (Month) (Day) (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 6, 1870
9. AGE last birthday 81 yrs. 05 Months 21 Days		10. If under 1 year 05 Months 21 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Petty Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? US(N)	
13. FATHER'S NAME Anthony BARRELLA		14. MOTHER'S MAIDEN NAME Mary PATIERNO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. -----	
17. INFORMANT AND ADDRESS Wife: Angelina BARRELLA		18. MEDICAL CERTIFICATION Same as item # 2	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **MYOCARDITIS, CHRONIC, WITH ACUTE CARDIAC FAILURE.**INTERVAL BETWEEN ONSET AND DEATH
1 day

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **ARTERIOSCLEROTIC HEART DISEASE****10 years.**(c) **DIABETES MELLITUS****10 years.**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

HYPERTROPHY, PROSTATE, BENIGN.**29 days.**

19a. DATE OF OPERATION June 25, 1951		19b. MAJOR FINDINGS OF OPERATION Hypertrophy, Prostate, Benign.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **June 1**, 19**51**, to **June 27**, 19**51**, that I last saw the deceased alive on **June 27**, 19**51**, and that death occurred at **2:42** A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. S. HANTEN, CDR, MC, USN**U.S. NAVAL HOSPITAL, BETHESDA, MD.****June 27, 1951**

23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF June 27, 1951		NAME OF CEMETERY OR CREMATORY B.L. Hopping Funeral Home	
LOCATION (City, town, or county) Annapolis, Maryland.		(State)		24. FUNERAL DIRECTOR B. L. Hopping Funeral Home, Annapolis, Maryland.	
DATE REC'D BY LOCAL REG. June 27, 1951		REGISTRAR'S SIGNATURE <i>Edith Whittington</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 113

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

RECEIVED
JUN 28 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

06065

1. PLACE OF DEATH- COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>RICHMOND, VA.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jolliffe Rest Home</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jolliffe Rest Home</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Jolliffe Rest Home</u>		STREET ADDRESS (If rural, give location) <u>Jolliffe Rest Home</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EVA</u>	(Middle) <u>Pinchback</u>	(Last) <u>BASS</u>
4. DATE OF DEATH	(Month) <u>JUNE</u>	(Day) <u>30</u>	(Year) <u>1951</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
9. AGE last birthday <u>81</u> yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MR Pincback</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Pincback</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebral accident - cerebral arteriosclerosis</u>	<u>at least 1 year</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Generalized arteriosclerosis</u>	"
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>Hypertensive heart disease.</u>	"
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19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 16, 1951, to June 30, 1951, that I last saw the deceased alive on June 29, 1951, and that death occurred at 11 m., from the causes and on the date stated above.

SIGNATURE <u>Ann H. Trau</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>8237 Georgia Ave Silver Spring Md.</u>	DATE SIGNED <u>June 30 51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>July 3/51</u>	NAME OF ZEMETERY OR CREMATORY <u>Oakwood</u>	LOCATION (City, town, or county) (State) <u>Richmond VA</u>
DATE REC'D BY LOCAL REG. <u>July 1, 1951</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Cherry Chase Funeral Home</u>	ADDRESS <u>5101 Wisconsin Ave N.W. Washington D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15



MARYLAND STATE DEPARTMENT OF HEALTH

06066

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rear of 8800 Block Piney Branch Road		STREET ADDRESS (If rural, give location) 913 Garland Ave.	
3. NAME OF DECEASED (Type or Print)	(First) James (Middle) Erwin (Last) Bellamy	4. DATE OF DEATH	(Month) June (Day) 27 (Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 31, 1924
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Lather		10b. KIND OF BUSINESS OR INDUSTRY T.M. Woodhall, Inc.	9. AGE last birthday 26 yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Bellamy		14. MOTHER'S MAIDEN NAME Evelyn C. Shriver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 243-20-0619	
17. INFORMANT Mrs. Pauline K. Bellamy			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

973.1

Immediate cause

(a) **Asphyxia due to Carbon-monoxide poisoning****within death.**

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

poisoning

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

Found dead in auto with hose attached to exhaust

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE THEREOF **June 29, 1951** NAME OF CEMETERY OR CREMATORY **Arlington National Cemetery** LOCATION (City, town, or county) **Arlington County Va.** (State)

DATE REC'D BY LOCAL REG. **6/28/51**

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Francis J. Broschart M.D. **Garthushay m.d.** **6-28-51**
Francis J. Broschart **Francis J. Broschart** **8434 Georgia Ave.**
Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
TOWN <u>Bethesda</u>		TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5514 Lincoln St.</u>		STREET ADDRESS (If rural give location) <u>5514 - Lincoln St. Bethesda, Md</u>	
3. NAME OF DECEASED (Type or Print) <u>CARL</u>	(First) <u>F.</u> (Middle)	(Last) <u>Bond</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>15</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec 9, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER OF LOEAN MOTORS, WASHDC.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MOTOR COMPANY</u>	9. AGE last birthday <u>59</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Laurel, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S</u>	
13. FATHER'S NAME <u>Carol Bond</u>		14. MOTHER'S MAIDEN NAME <u>Mary Flester</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>578-03-1562</u>	
17. INFORMANT <u>Helen B. Bond - same as above</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Arteria sclerosis - coronary artery sclerosis</u>	<u>2 yrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Chronic whole cystitis</u>	
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF	While at	Not While		
INJURY	Work	At work		

22. I hereby certify that I attended the deceased from April 24, 1951, to June 15, 1951, that I last saw the deceased alive on June 15, 1951, and that death occurred at 7 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>June 18, 1951</u>	<u>ROCK CREEK, WASH. D.C.</u>	<u>WASHINGTON D.C.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-18/51</u>	<u>Bessie M. Thompson</u>	<u>W. Warren Taltanall</u>	<u>3619-14th St. N.W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06068

Reg. Dist. No. 212

1. PLACE OF DEATH COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sellman</u>		LENGTH OF STAY (In this place) <u>rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sellman</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>rural</u>	
3. NAME OF DECEASED (Type or Print) <u>Ulysses</u>		(First) (Middle) (Last) <u>Bond</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 25 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 3, 1895</u>	9. AGE last birthday <u>55</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Ulysses Bond</u>		14. MOTHER'S MAIDEN NAME <u>Cassie Bond</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>#1</u>		INFORMANT AND ADDRESS <u>Jeanelle Snowden 759 Reservoir Rd. Wash. D.C.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <u>Coronary occlusion</u>				<u>sudden death</u>	
Antecedent cause(s) (b) <u>420.1 Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>					
SIGNATURE <u>Frank J. Broschart M.D.</u>				DATE SIGNED <u>6-25-51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>6/29/51</u>		NAME OF CEMETERY OR CREMATOR <u>Arlington Nat. Arlington Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 28/52</u>		REGISTRAR'S SIGNATURE <u>Robert L. Snowden</u>		24. FUNERAL DIRECTOR <u>Robert L. Snowden, Rockville, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

820105

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06069

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 1808 Branch Avenue, S.E.	
3. NAME OF DECEASED (First) Byron (Middle) Beltran (Last) BRADLEY		4. DATE OF DEATH (Month) June (Day) 19 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 27, 1894
9. AGE last birthday 57 yrs.		10. If under 1 year Months 03 Days 22 If under 24 hrs. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY US Gov't	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Horace BRADLEY		14. MOTHER'S MAIDEN NAME Lulu STONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. -----	
17. INFORMANT AND ADDRESS Wife: Carrie BRADLEY		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 416X Antecedent cause(s) 95b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(a) Rheumatic Heart Disease, Inactive type	
(b)			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 21 , 19 51 , to June 19 , 19 51 , that I last saw the deceased alive on June 19 , 19 51 , and that death occurred at 10:41 P .m., from the causes and on the date stated above.			
SIGNATURE J. W. FLYNN, LTJG, MC, USN		ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
DATE SIGNED June 20, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF June 22, 1951	
LOCATION (City, town, or county) Cedar Hill Cemetery		(State) Washington, D.C.	
24. FUNERAL DIRECTOR S. H. Hines Funeral Home, 2901 14th Street, NW, Washington, D.C.		ADDRESS 2901 14th Street, NW, Washington, D.C.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 21 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

06070

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind.</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Silver Spring</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cedarcroft Sanitarium</u>		STREET ADDRESS (If rural, give location) <u>11-East Franklin</u>	
3. NAME OF DECEASED (Type or Print) <u>Blanche</u> (First) <u>Jessie</u> (Middle) <u>Brähler</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>2</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Oct. 12-1880</u>
9. AGE last birthday <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robt. Hudlow</u>		14. MOTHER'S MAIDEN NAME <u>Abbie Bellman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Conrad Mang. 11-E. Franklin Ave.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

(b)

Cerebral arteriosclerosis2

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6/5, 1950, to 6/, 1957, that I last saw the deceasedalive on 6/2, 1957, and that death occurred at 2:35 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>6/5/57</u>	<u>Mt. Olivet Cemetery</u>	<u>Washington</u>	<u>D.C.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<u>6/5/57</u>	<u>Frances Polter</u>	<u>Valley's Funeral Home 3200-R, P. Ave</u>		
<u>Mt. Rainier, Md.</u>				

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-7

Sh. 9212.

RECEIVED
JUN 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06071

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>103 Dresden St. Kensington</u>		STREET ADDRESS (If rural, give location) <u>103 Dresden Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Marie</u>	(Middle) <u>V</u>	(Last) <u>Brede</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-14-1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Voll</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Voll</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Edwin P. Lang-same as Item #2</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Cerebral thrombosis, multiple

(b) Arteriosclerosis, generalised, severe

(c) Rheumatoid Arthritis, severe

Bronchiectasis, bilateral

INTERVAL BETWEEN ONSET AND DEATH

6 days

5 yrs.

5 yrs +

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May, 1950, to June 11, 1951, that I last saw the deceased alive on June 6, 1951, and that death occurred at 8:10 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>June 12, '51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) <u>Switland Maryland</u>
DATE REC'D BY LOCAL REG. <u>6-12-51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

06072

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>	
TOWN <u>St. Louis Springs</u>		TOWN <u>West Hyattsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium</u>		STREET ADDRESS (If rural, give location) <u>8303-14th Ave.</u>	
3. NAME OF DECEASED (First) <u>Barry</u> (Middle) <u>Hugh</u> (Last) <u>Broom</u>		4. DATE OF DEATH (Month) <u>6/10/51</u> (Day) <u>19</u> (Year) <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6/8/51</u>
9. AGE last birthday <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bert Washington Broom</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Louise Robertson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Heart + respiratory failure

INTERVAL BETWEEN ONSET AND DEATH

2 hrs.

Antecedent cause(s)

(b) Cerebral anoxia
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(c) Placenta previa.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify) No

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 8, 1951, to June 10, 1951, that I last saw the deceasedalive on June 10, 1951, and that death occurred at 8:40 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE REC'D BY LOCAL REG. 6-11-51DATE THEREOF 6-11-51

REGISTRAR'S SIGNATURE

NAME OF CEMETERY OR CREMATORY

Washington San. & Hosp.

LOCATION (City, town, or county)

Takoma Park, 12, Md.

(State)

24. FUNERAL DIRECTOR

ADDRESS Washington San. & Hosp. Takoma Park, Md.

ADDRESS

W.H. Hyatt, Med. Record Librarian

Written permission rec'd from both parents

W.H. Hyatt

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

206081284404

BUREAU V. S.

JUN 13 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06073

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Dist. of Col.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital 8600 Chillum Rd.</u>		STREET ADDRESS (If rural, give location) <u>4939 - 30th Pl. N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>Rudell Renfrew</u> (First) <u>Burham</u> (Middle) <u>Burham</u> (Last)		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 15, 1865</u>
9. AGE last birthday <u>86</u> yrs.		10. If under 1 year: Months <u>2</u> Days <u>2</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Newbury, Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew Renfrew</u>		14. MOTHER'S MAIDEN NAME <u>Hovina Witcher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Raleigh Gilchrist - Nephew</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Diverticulitis(c) arterio sclerosisINTERVAL BETWEEN ONSET AND DEATH
present on 1st visit7 wks present on 1st visit

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/14/1951, to 6/22/1951, that I last saw the deceasedalive on June 22, 1951, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

B. Irene Bradley BarrettMD 6900 W. Ave Chevy Chase Md

23. BURIAL, CREMATION, REINTERMENT, (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial transit6/22/51Littleton CemeteryLittleton, New Hampshire

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/22/51Bessie M. ThompsonRobert W. Humphrey Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The subject age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 25 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06074

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and OR TOWN <u>Rural Silver Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bonifant Rd - RFD#1</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Silver Spring</u> STREET ADDRESS (If rural, give location) <u>Bonifant Rd - RFD#1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Viola</u>	(Middle) <u>Margaret</u>	(Last) <u>Burriss</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/27/1905</u>
9. AGE last birthday <u>46</u> yrs.		10. DATE OF DEATH <u>6 24 1951</u>	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charlie Lee Burriss</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Burriss (same name)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Husband W. Earl Burriss Silver Spring, Rtl., Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Carcinomatosis
(b) Carcinoma of breasts, left.
(c)

INTERVAL BETWEEN ONSET AND DEATH

4 mo.
6 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1948, to....., 6/24, 1951, that I last saw the deceased

alive on....., 1951, and that death occurred at....., 7:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 6-25-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06075

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
TOWN <u>Meadebrook</u> LENGTH OF STAY (in this place) <u>few hrs.</u>		TOWN <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>8211 Flower Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM (First) Albert (Middle) ALBERT (Last) Butler</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 28 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>July 9, 1888</u>
9. AGE last birthday <u>62</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. CONF. of SDA</u>	
11. BIRTHPLACE (State or foreign country) <u>Lynchburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Mary Morrison</u>	
15. WAS DECEASED EVEN IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Allen Lucille Butler, 8211 Flower Ave. Tak. Park, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>		<u>sudden death</u>
Antecedent cause(s) (b) <u>420.1</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) Frank J. Brochart M.D. ADDRESS Gaithersburg, Md. DATE SIGNED 6-28-57

23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>July 2, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>	LOCATION (City, town, or county) <u>Riggs Rd., Hyattsville, P. GEO. Co., Md.</u>
DATE REC'D BY LOCAL REG. <u>July 1, 1951</u>	REGISTRAR'S SIGNATURE <u>Francis Potter</u>	24. FUNERAL DIRECTOR <u>Arthur Staller</u>	ADDRESS <u>254 Carroll St. W.</u>

0095 Takoma Park 12, D.C.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06076

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Woodmoor Drive		STREET ADDRESS (If rural, give location) 15 Woodmoor Drive	
3. NAME OF DECEASED (Type or Print)	(First) Bertha Ellen	(Middle) Wardell	(Last) Calaway
4. DATE OF DEATH	(Month) June	(Day) 2	(Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 29, 1878
9. AGE last birthday 73 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Rockland, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Linton Wardell		14. MOTHER'S MAIDEN NAME Anne E. Ferguson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Mrs. Ralph Godwin		15 Woodmoor Drive, Silver Spring, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Heart Block

Antecedent cause(s)

(b)

arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Apr. 14**, 19**51**, to **June 2**, 19**51**, that I last saw the deceased alive on **June 1**, 19**51**, and that death occurred at **7 a.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6/5/51	NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	LOCATION (City, town, or county) Easton, Maryland	(State) MD
DATE REC'D BY LOCAL REG. 6/3/51	REGISTRAR'S SIGNATURE James Potter	24. FUNERAL DIRECTOR Warner & Humphrey	ADDRESS 8434 Georgia Ave. Silver Spring, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED

JUN 6 1951

BUREAU V. J.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06077

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural, give location) <u>2505 McComus Ave.</u>	
3. NAME OF DECEASED (First) <u>Edna</u> (Middle) <u>Florence</u> (Last) <u>Carson</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 14, 1896</u>
9. AGE last birthday <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co., Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Zapp</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Barber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>George V. Carson, Husband, (same) 12212</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

175X Antecedent cause(s)
49a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Generalized Carcinomatosis
(b) Carcinoma (Cystadenoma) Rt. Ovary.
(c)

INTERVAL BETWEEN ONSET AND DEATH 1 year

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 21, 1943, to June, 1951, that I last saw the deceased alive on June 10, 1951, and that death occurred at 12:05 PM, from the causes and on the date stated above.

SIGNATURE:

(Degree or title)

ADDRESS

DATE SIGNED

address: Beth. Md.

J.A. McArthur M.D.

6/11/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial-Transit</u>	<u>12 June 1951</u>	<u>Richview Cemetery</u>	<u>Richview, Ill.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-12-51</u>	<u>Bessie M. Thompson</u>	<u>Robert H. Humphrey</u>	<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 441

RECEIVED
JUN 15 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

06078

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Roland</u>	(Middle)	(Last) <u>Carter</u>
4. DATE OF DEATH	(Month) <u>6</u>	(Day) <u>5</u>	(Year) <u>1951</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>12-5-16</u>
9. AGE last birthday <u>34</u> yrs.	If under 1 year Months	If under 24 hrs. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic - kitchen</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Carter</u>		14. MOTHER'S MAIDEN NAME <u>Annie Chase</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Myrtle Butler (sister) - same</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Sickle Cell Anemia with secondary hepatitis

Antecedent cause(s)

(b) Hypoproteinemia with anasarca

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Cardiac Decompensation

INTERVAL BETWEEN ONSET AND DEATH

?

2 wks

10 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 15, 1951, to June 5, 1951, that I last saw the deceased

alive on June 5, 1951, and that death occurred at 7:25 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 6/8/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Bessie M. Thompson

Prof W. Barber

220 826 mg

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

06079

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write nearest town) <u>Silver Spring</u>	
TOWN <u>Suburban</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS <u>11807 Galt Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Toy</u> (Middle) <u>Lan</u> (Last) <u>chin</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8/28/1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year (Months) (Days) (Hours) (Min.)
11. BIRTHPLACE (State or foreign country) <u>Canton, China</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vue Toy</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Grace Choy</u> <u>11807 Galt Ave. Sil. Sprg., Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Pulmonary atelectasis & pneumonia</u>	<u>4 d.</u>
Antecedent cause(s)	(b) <u>Duodenal fistula</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Common duct obstruction</u>	
II. OTHER SIGNIFICANT CONDITIONS	(d) <u>Intestinal obstruction due to cholelithiasis</u>	
19a. DATE OF OPERATION <u>6-9-51</u>	19b. MAJOR FINDINGS OF OPERATION <u>above - stone in duodenum</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-2, 1951, to 6-23, 1951, that I last saw the deceased alive on 6-23, 1951, and that death occurred at MD. m., from the causes and on the date stated above.

SIGNATURE Dorothy Hill (Degree or title) ADDRESS 7011 arlington Rd. DATE SIGNED 6-24-51

23. BURIAL, CREMATION REMOVE (Specify) <u>Burial</u>	DATE <u>6/26/51</u>	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State) <u>Seattle, Wash.</u>
DATE REC'D BY LOCAL REG. <u>6/25/51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>	ADDRESS <u>1400 Chapin St. Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

VS. A15

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 27 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06080

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY Arlington	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Arlington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 32 South Aberdeen	
3. NAME OF DECEASED (First) Harris (Middle) Lenard (Last) CHRISTIANSEN	4. DATE OF DEATH (Month) June (Day) 6 (Year) 1951		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 23, 1908
9. AGE last birthday 43 yrs. If under 1 year 0 months 13 days		10. If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not known		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Benjamin CHRISTIANSEN		14. MOTHER'S MAIDEN NAME Sophia DAHL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give year or dates of service) WW II		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS Wife: Jean CHRISTIANSEN		18. MEDICAL CERTIFICATION Same as item # 2	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Congestive Heart Failure			3 yrs
Antecedent cause(s) (b) Acute Bacterial Endocarditis			3 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Rheumatic Heart Disease			4 yrs
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at <input type="checkbox"/> Not While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 25, 1950 , to June 6, 1951 , that I last saw the deceased alive on June 6, 1951 , and that death occurred at 8:05 P. m., from the causes and on the date stated above.			
SIGNATURE J. W. FLYNN, LTJG, MC, USN		ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
DATE SIGNED June 7, 1951			
23. BURIAL, CREMATION, REMOVAL (Specify) Removal	DATE THEREOF June 7, 1951	NAME OF CEMETERY OR CREMATORY Riverside Cemetery	LOCATION (City, town, or county) (State) Superior, Wisconsin
DATE REC'D BY LOCAL REG. June 7, 1951	REGISTRAR'S SIGNATURE Earl Whittington	24. FUNERAL DIRECTOR W. W. Chambers, 3072 M Street, NW, Washington, D.C. (Adm.)	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06081
Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Rockville		CITY (If outside corporate limits, write RURAL and give nearest town) Rockville	
TOWN At Home		TOWN Rockville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS At Home		STREET ADDRESS (If rural, give location) 1108 Edmonston Drive	
3. NAME OF DECEASED (First) (Middle) (Last) Square Brinson Clark		4. DATE OF DEATH (Month) (Day) (Year) June 8 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 10-16-1900
9. AGE last birthday 50 yrs.		10. If under 1 year 7 days 22 hours 1 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Atty. Dept. of Labor		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lake Clark		14. MOTHER'S MAIDEN NAME Cynthia Brinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Mrs. Cynthia Clark, -Same as Item 2			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) coronary occlusion		1-2 days
Antecedent cause(s) (b) arteriosclerotic heart disease		1 year
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) auricular fibrillation		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec 1942**, to **6/8, 1951**, that I last saw the deceased alive on **6/7, 1951**, and that death occurred at **a. m.**, from the causes and on the date stated above.

SIGNATURE **James J. Burns M.D.** ADDRESS **915 19th St NW - Wash DC** DATE SIGNED **6/4/51**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial - Transit	6-12-51	Methodist Church Cem.	Stillmore	Georgia
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
6/9/51	John C. Eckenfelder	James B. Humphrey	Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

055-916

RECEIVED
JUN 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06082

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattstown - rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>dead on arrival car</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Copeland</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan 9, 1906</u>
9. AGE last birthday <u>45</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabney</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Refuge Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Montgo. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>James S. Copeland</u>	
14. MOTHER'S MARRIED NAME <u>Martha Miles</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war and dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Edna Johnson (sister)</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Abdominal hemorrhage due to rupture of left Ext. iliac artery

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY <u>street</u>	(CITY OR TOWN) <u>Silver Spring</u> (COUNTY) <u>Montg</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 9-51-2:42 P.</u>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Ran over after falling from truck</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. (BURIAL) CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 13, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	LOCATION (City, town, or county) (State) <u>Mt. Zion, Md.</u>
DATE REC'D BY LOCAL REG. <u>6/14/51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robt. L. Snowden</u>	ADDRESS <u>Rockville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

BUREAU V. S.

JUN 18 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06083

Reg. Dist. No. 218

1. PLACE OF DEATH- COUNTY <u>Montg Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gaithersburg. Rural</u> LENGTH OF STAY (In this place) <u>61 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gaithersburg. Rural</u> STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <u>ROBERT</u> (First) (Middle) <u>CRAWFORD</u> (Last)		4. DATE OF DEATH <u>June 18th</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 3, 1890</u> 61 yrs. 18 Months 18 Days 18 Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal Work. Montg. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John S. Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Frances A. Purdum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>218-09-5112</u>	
17. INFORMANT <u>Theodore Crawford. Gaithersburg. Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CORONARY OCCLUSION

INTERVAL BETWEEN ONSET AND DEATH

5 min

Antecedent cause(s)

(b) CARDIAC INSUFFICIENCY2 WEEKS

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) ARTERIO SCLEROSIS5 YEARS11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify) none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒TIME (Month) (Day) (Year) (Hour) OF INJURY noneINJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY, 1949, to 18 June, 1951, that I last saw the deceased alive on 16 June 1951, and that death occurred at 1 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial 6/21/51 Forest Oak
June 21, 1951 Abraham L. Sode

Ernest C. Gartner, Gaithersburg, Md.
970246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 23 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06084

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Silver Spring</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2503 Booker Rd</u>		STREET ADDRESS <u>2503 Booker Rd</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>Valleria</u> (Middle) <u>Constance</u> (Last) <u>Field</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>5-18-51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>22</u> If under 1 year Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min. <u>22</u>
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thaddeus Constance Field</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Lancaster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Father</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Asphyxia due to Vomiting

Antecedent cause(s)

(b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

Found dead in bed.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. FUNERAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 21 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06085

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u> LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>216 Rosemary St.</u>	
3. NAME OF DECEASED (First) <u>Jessie</u> (Middle) <u>R.</u> (Last) <u>CUSHMAN</u>	4. DATE OF DEATH (Month) <u>6</u> (Day) <u>19</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 12 1870</u>
9. AGE last birthday <u>80</u> yrs. If under 1 year Months <u>6</u> Days <u>27</u> If under 24 hrs. Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. FATHER'S NAME <u>Adoniram Manley</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. MOTHER'S MAIDEN NAME <u>Doliska Rathburn</u>		14. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>B. Cushman - New York, N.Y.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Myocardial Decompensation

INTERVAL BETWEEN ONSET AND DEATH

4 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary arteriosclerosis with insufficiency(c) Hypertensive cardio-vascular-renal disease5 yrs +

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Rt. Hemiplegia1 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 June, 1951, to 9 June, 1951, that I last saw the deceasedalive on June 8, 1951, and that death occurred at 5:30 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>6/11/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, or county) <u>Landover, Maryland</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>6/11/51</u>	REGISTRAR'S SIGNATURE <u>Berice M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert G. Humphrey, Beth., Md.</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06086

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> TOWN <u>2 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sans Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D.C.</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cavalier Hotel 14th St N.W.</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>Walter</u> (Last) <u>Deards</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, <u>WIDOWED</u> , DIVORCED, (Specify)	8. DATE OF BIRTH <u>Apr. 19, 1867</u>
9. AGE last birthday <u>84</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Wis.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Deards sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Force</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Hosp. Charts</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Sub-arachnoid hemorrhage</u>		<u>4/25/51</u>	
Antecedent cause(s) (b) <u>diab. mellitus</u>		<u>6/28/51</u>	
(c) <u>cerebral art. Sclerosis</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6/28</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/25</u> , 19 <u>51</u> , to <u>6/28</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>51</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Norman Paul M.D.</u>		ADDRESS <u>3557-16th Washington SE 28/28/51</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>6-28-51</u>		NAME OF CEMETERY OR CREMATORY <u>Bedon Hill Maus.</u>	
DATE REC'D BY LOCAL REG. <u>6-28-51</u>		24. FUNERAL DIRECTOR <u>S.H.H. Inc. 2901-14th St. N.W.</u>	

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06087

Reg. Dist. No. 216

1. PLACE OF DEATH - COUNTY <u>Montg</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Alfred</u> (Middle) <u>Dickerson</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>19</u> (Year) <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>6-7-1917</u>
9. AGE last birthday <u>34</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labourer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jessie Dickerson</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Bowie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>mother -</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of lung with

Antecedent cause(s)

(b) pleurisy and effusion

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

no

history

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-19-51

Bessie M. Thompson

W. Ement Jarvis Co. 1432 9th St. N.W. Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

RECEIVED

JUN 22 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06088

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
TOWN <u>Bethesda</u>		TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Henry</u> (First) (Middle) (Last) <u>Dorsey</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 14 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov 1 1871</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Ollie Bright - 1929-15th St. N. W.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral embolism</u>		<u>sudden</u>	
Antecedent cause(s) (b) <u>Comp. Communicated and simple fracture of tibia and fibula, Rt.</u>		<u>8 days</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>street</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 7 5:14.56 PM</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>Struck by auto</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Brosehart M.D.</u>		DATE SIGNED <u>6-14-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Sandy Spring</u>	
DATE REC'D BY LOCAL REG. <u>6-18-57</u>		REGISTERAR'S SIGNATURE <u>Robert L. Sauerbrey</u>	
		24. DECEASED'S ADDRESS <u>Rockville</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16A

RECEIVED

JUN 20 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06089

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR give nearest town) <u>Ashton</u>		CITY (If outside corporate limits, write OR TOWN <u>Ashton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Potomac River</u>		STREET ADDRESS <u>rural</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Mildred H</u> (First) (Middle) (Last) <u>DRAKE</u>		4. DATE OF DEATH <u>June 4</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/30/1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Warren F. Hull</u>		14. MOTHER'S MAIDEN NAME <u>Emma E. Daniles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Milk Hollow, Ashton, Md</u>		17. INFORMANT AND ADDRESS <u>Lt. Col. Albert F. Drake</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Asphyxia by drowning</u>		<u>Sudden death</u>
Antecedent cause(s) (b) <u>229.8</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>183</u> (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office, hdg., etc.) <u>Potomac R.</u>	(CITY OR TOWN) <u>Ashton</u> (COUNTY) <u>Montgomery</u> (STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 4 5:13:30 p.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>drowned while bathing</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>Frank J. Broschart M.D.</u> (Degree or title)		DATE SIGNED <u>6-4-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State)
DATE REC'D BY LOCAL REG. <u>6-7-51</u>	REGISTRAR'S SIGNATURE <u>Gertrude B. Lander</u>	24. FUNERAL DIRECTOR <u>Wm. L. Humphrey</u> ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUN 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8315 Conn. Ave.</u>		STREET ADDRESS (If rural, give location) <u>8315 Conn. Ave.,</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JAMES</u> (Middle) <u>ROSS</u> (Last) <u>DuSHANE</u>	4. DATE OF DEATH	(Month) <u>June</u> (Day) <u>18</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>March 21/92</u>
9. AGE last birthday <u>59</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Apple Broker</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <u>Davenport, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James D. DeShane</u>		14. MOTHER'S MAIDEN NAME <u>Marion Ross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Edward Northrop- same as Item #2</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Malignancy of Throat

INTERVAL BETWEEN ONSET AND DEATH

1 yr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 17, 1951, to June 18, 1951, that I last saw the deceased alive on June 17, 1951, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

SIGNATURE Richard B. Rude M.D. APPROVED BY Montg. Co. Med. Ex. ADDRESS 3900 Military Rd. N.E. DC DATE SIGNED June 18, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>6/20/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
DATE REC'D BY LOCAL REG. <u>6-20-51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>	ADDRESS <u>Bethesda, Md.</u>

(XXXX)

290W

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Montgomery County Medical Examiner notified
and approval signature.

BUREAU V. S.

JUN 22 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06091

Reg. Dist. No. 218

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		MARYLAND LENGTH OF STAY (in this place) <u>dead on arrival</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montg</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u> TOWN <u>Derwood</u> STREET ADDRESS <u>R 2 J.</u> (If rural, give location) <u>(Redland)</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Edward</u> (Middle) <u>Earp</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>19</u> (Year) <u>1951</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W. White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 14 1942</u>	9. AGE last birthday <u>9</u> yrs. If under 1 year Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Derwood, Md. (Maryland)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John E. Earp</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Buttry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>John E. Earp - Derwood Rd. 2 J.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Cerebral hemorrhage due to</u>	INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
Antecedent cause(s) (b) <u>fracture of skull</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>1700</u>	

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office, etc.) OF INJURY <u>highway</u>	(CITY OR TOWN) <u>Redland</u> (COUNTY) <u>Montg</u> (STATE) <u>md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 19 '51 - 12:30 p.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Struck by auto while crossing highway</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/22/51</u>	NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	LOCATION (City, town, or county) <u>Gaithersburg, Md.</u> (State) <u>md</u>
DATE REC'D BY LOCAL REG. <u>June 21, 1951</u>	REGISTRAR'S SIGNATURE <u>Abundel G. Cooke</u>	24. FUNERAL DIRECTOR <u>Frank L. Gaithersburg</u> ADDRESS <u>md</u>	

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
JUN 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

06092

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8306 Queen Anne's Drive</u>		STREET ADDRESS (If rural, give location) <u>8306 Queen Anne's Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>W.</u> (Last) <u>Eiter</u>	4. DATE OF DEATH	(Month) <u>June</u> (Day) <u>13</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 18, 1908</u>
9. AGE last birthday <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Peter Eiter</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Malkmus</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-09-0278</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Irene M. Eiter, 8306 Queen Anne's Dr. Silver Spring, Maryland</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

6 hrs.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6-12, 1951, to 6-13, 1951, that I last saw the deceased alive on 6-12, 1951, and that death occurred at 3 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/16/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Mary's Catholic Cemetery</u>	LOCATION (City, town, or county) <u>Washington, D. C.</u>	(State)
DATE REC'D BY LOCAL REG. <u>6/4/51</u>	REGISTRAR'S SIGNATURE <u>Frances J. Toller</u>	24. FUNERAL DIRECTOR <u>Warner & Pumphrey</u>	ADDRESS <u>8434 Georgia Ave. Silver Spring, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 47

RECEIVED

JUN 15 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06093

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sen. & Hosp.</u>		STREET ADDRESS (If rural, give location) <u>8409 Grove St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Ernest</u> (Middle) <u>Gilbert</u> (Last) <u>Eslin</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>17</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>6-27-1925</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dist. of Columbia</u>	9. AGE last birthday <u>58</u> yrs. If under 1 year Months Days Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles Eslin</u>		14. MOTHER'S MAIDEN NAME <u>Mary McMahon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>World War I</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Hospital Charts</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Pulmonary Hemorrhage</u>		<u>Sudden</u>
Antecedent cause(s) (b) <u>Pneumonia Tbc.</u>		<u>10 Days.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Tuberculosis.</u>		<u>1 yr.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May 38, 1957, to June 17, 1957, that I last saw the deceased alive on June 17, 1957, and that death occurred at 1 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) BurialDATE THEREOF 6/20/57NAME OF CEMETERY OR CREMATORY St. John's Catholic CemeteryLOCATION (City, town, or county) Montgomery County(State) Md.DATE REC'D BY LOCAL REG. 6-19-57REGISTRAR'S SIGNATURE William D. Dod24. FUNERAL DIRECTOR Warren B. Pumphrey

ADDRESS

8434 Georgia Ave. Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06094

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>Silver Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2506 Lindell Street</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY <u>Montgomery & Md.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>2506 Lindell Street</u> STREET ADDRESS <u>Silver Spring, Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>CATHERINE VIRGINIA EVERETT</u>		4. DATE OF DEATH <u>JUNE 13, 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT. 31, 1858</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>92</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES ARTHUR BRIDGET</u>		14. MOTHER'S M maiden name <u>ANN ELIZABETH SANVER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>DAUGHTER (MARIE L. LINDEN)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

4500 Immediate cause (a) Generalized arteriosclerosis97 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardiac failure(c) NoneII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

none none

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY none INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1917, to late, 1957, that I last saw the deceasedalive on June 12, 1951, and that death occurred at 7:15 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/16/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	LOCATION (City, town, or county) <u>Washington DC</u>	(State) <u>D.C.</u>
---	-----------------------------	--	---	---------------------

DATE REC'D BY LOCAL REG. 6/13/51REGISTRAR'S SIGNATURE Francis J. Hines24. FUNERAL DIRECTOR 4th S.H. Hines & Co.ADDRESS 2901-14th NW Wash D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 15 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06095

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium and Hosp.</u>		STREET ADDRESS (If rural, give location) <u>415 Columbia Rd. N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>Alice</u> (First) <u>May</u> (Middle) <u>Farr</u> (Last)		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-27-1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Rightstine</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Hypostatic Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

Terminal

Antecedent cause(s)

(b)

Hypertension - with uremic stateyears

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Diabetes Mellitus

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 10, 1951, to June 13, 1951, that I last saw the deceased

alive on June 13, 1951, and that death occurred at 6:10 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 15, 1951</u>	<u>Shenwood</u>	<u>Washington</u>	<u>D.C.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-13-51</u>	<u>J. M. M. Root</u>	<u>Arthur H. Walters</u>	<u>254 Carroll St. Takoma Park, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 15 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06096

Reg. Dist. No. 223

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Col.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hosp.</u>		STREET ADDRESS (If rural, give location) <u>430 Buchanan St. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mathilde</u>	(Middle) <u>(Mrs)</u>	(Last) <u>FitzGerald</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>25</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	8. DATE OF BIRTH <u>Aug. 22, 1873</u>	9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Henry Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Marie Goethe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Patients Chart - Washington San & Hosp.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Luauition</u>			<u>Terminal</u>
151X Antecedent cause(s) (b) <u>Metastatic Carcinoma</u>			<u>One Year.</u>
46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Carcinoma of Stomach</u>			<u>Two Years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>9-6-49</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Stomach</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug., 1949, to June 25, 1951, that I last saw the deceased alive on June 25, 1951, and that death occurred at 8:00 P. m., from the causes and on the date stated above.

SIGNATURE Robert A. Harems (Degree or title) ADDRESS Takoma Park Md. DATE SIGNED 6/25/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	<u>6-27-51</u>	<u>St. Lincoln</u>	<u>Lyngers</u>	<u>md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-25-51</u>	<u>[Signature]</u>	<u>The Ditt-Hines Co</u>	<u>2901-148 St. N.W. Washington D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A187

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06097

1. PLACE OF DEATH - COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		LENGTH OF STAY (in this place) 8 days		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural, give location) 212 St. Dunstons Road			
3. NAME OF DECEASED (First) Henry		(Middle) Peter		(Last) FRANK		4. DATE OF DEATH (Month) (Day) (Year) June 8, 1951	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 16, 1889	
9. AGE last birthday 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Cuba	
12. CITIZEN OF WHAT COUNTRY? US(N)		13. FATHER'S NAME Louis FRANK		14. MOTHER'S MAIDEN NAME Rose MATAMORES		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II	
16. SOCIAL SECURITY No. ---		17. INFORMANT AND ADDRESS Wife: Elizabeth FRANK		18. MEDICAL CERTIFICATION Same as item # 2			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Thrombosis, left posterior cerebral and basilar arteries*

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Atherosclerosis, generalized*

(c)

INTERVAL BETWEEN ONSET AND DEATH
20 hrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **May 30**, 19**51**, to **June 8**, 19**51**, that I last saw the deceased

alive on **June 8**, 19**51**, and that death occurred at **11:36 P.** m., from the causes and on the date stated above.

(Degree or title)

ADDRESS

DATE SIGNED

J. R. RYNOLDS, LTJG, MCR, USNR U.S. NAVAL HOSPITAL, BETHESDA, MD. June 9, 1951

23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF June 14, 1951		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REG June 9, 1951		REGISTRAR'S SIGNATURE <i>Edith Whittington</i>		24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland.		ADDRESS Robert A. Pumphrey CDC.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED
JUN 13 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06098

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
TOWN _____		TOWN _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sen + Hosp</u>		STREET ADDRESS (If rural, give location) <u>48 Adams St. N.W.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Lydia</u> (Middle) <u>Franklin</u> (Last) <u>Fultz</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Fe</u> 6. COLOR OR RACE <u>Caucasian</u>		8. DATE OF BIRTH <u>Sept 15 1864</u> 9. AGE last birthday <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Wesley Casper</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Amy Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Congestive Cardiac Failure

Antecedent cause(s)

(b) Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Cystitis - Nephrotic

INTERVAL BETWEEN ONSET AND DEATH

terminalyearsone year

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 4, 1949, to 6-13, 1951, that I last saw the deceasedalive on 6-12, 1951, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUN 15 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06099

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. Hosp.</u>		STREET ADDRESS <u>7213 15th Ave</u>	
3. NAME OF DECEASED (First) <u>Esther</u>	(Middle) <u>Becker</u>	(Last) <u>Goren</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>11</u> (Year) <u>1951</u>
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Hebrew</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Siegel</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Bahaon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Hosp Records.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Thrombosis - inf. vena cava

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary heart disease - myocardial infarct(c) Hypertension - generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arteriosclerosis - nephritis.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1946, to 6/12....., 1951, that I last saw the deceased alive on 6/10....., 1951, and that death occurred at 9:15 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL - CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>6-12-51</u>	<u>Beth Shalom</u>	<u>Cap Height Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6/11/51</u>	<u>J. Nelson Dodd</u>	<u>B. Dargatzis & Son</u>	<u>Wash. D.C.</u>

3501 14th St NW

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 13 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06100

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
TOWN <u>Home</u>		TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		STREET ADDRESS (If rural, give location) <u>7115 Marion Lane</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>PAULA</u> <u>MAE</u> <u>GROOME</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>21</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 25, 1940</u>
9. AGE last birthday <u>11</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Patterson, N.J.</u>	
11. BIRTHPLACE (State or foreign country) <u>Patterson, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Preston E. Groome</u>		14. MOTHER'S MAIDEN NAME <u>Betty Smerdea</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Preston E. Groome Bethesda 14, Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Asphyxia</u>		<u>10 min.</u>
Antecedent cause(s) (b) <u>Brain Tumor, glioma, type not determined</u>		<u>10 months</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>193X 54a</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>Sept. 1950, March & May 1951</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION <u>Tumor of Brain - invasive Left Frontal - Area</u>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1950, to June, 1951, that I last saw the deceased alive on 21 June, 1951, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE John S. Bell (Degree or title) M.D. ADDRESS 7936 Georgetown Rd. Bethesda, Md. DATE SIGNED 21 June 51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>June 23/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	LOCATION (City, town, or county) (State) <u>Washington</u> <u>D. C.</u>
DATE REC'D BY LOCAL REG. <u>6/23/51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06101

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>142 Maple Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Kenneth Lee</u>	(Middle)	(Last) <u>Haley</u>
4. SEX <u>Male</u>	5. COLOR OR RACE <u>White</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	7. DATE OF BIRTH <u>June 22, 1951</u>
8. AGE last birthday <u>6</u> yrs.		9. DATE OF DEATH <u>June 27, 1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Kenneth Mead Haley</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Lee Depew</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr. Kenneth Mead Haley, 142 Maple Ave.</u>			

18. MEDICAL CERTIFICATION

Kensington, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Peritonitis, generalized, cause undetermined 72 hrs.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Pneumothorax, left, complete, cause undetermined Congenital

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 22, 1951, to June 27, 1951, that I last saw the deceased alive on June 27, 1951, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSITION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/29/51</u>	<u>Layhill Cemetery</u>	<u>Montgomery County</u>	<u>Md.</u>

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6/29/51</u>	<u>Bessie M. Thompson</u>	<u>Warner & Humphrey</u>	<u>8434 Ga. Ave.</u>

Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

20629181404



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06102

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY Prince William	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Quantico	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital		STREET ADDRESS (If rural, give location) General Delivery	
3. NAME OF DECEASED (Type or Print) William (First) (none) (Middle) HALSEY (Last)		4. DATE OF DEATH (Month) June (Day) 25 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Jan. 24, 1882
9. AGE last birthday 69 yrs.		10. If under 1 year 05 Months 01 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Enlisted Man		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Nelson HALSEY		14. MOTHER'S MAIDEN NAME Jane A. BURTS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Brother: Clarence HALSEY, 520 1/2 Summer St.,			

18. MEDICAL CERTIFICATION

Appleton, Wisconsin

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **EPIDERMOID CARCINOMA, NASOPHARYNX, WITH METASTASES**

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **May 11**, 19**51**, to **June 25**, 19**51**, that I last saw the deceased alive on **June 25**, 19**51**, and that death occurred at **10:32 P.** m., from the causes and on the date stated above.

SIGNATURE **H. R. Morse**

(Degree or title)

ADDRESS

DATE SIGNED

H. R. MORSE, LTJG, MCR, USNR

U.S. NAVAL HOSPITAL, BETHESDA, MD.

June 29, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF July 2, 1951	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) Arlington, Virginia	(State)
DATE REC'D BY LOCAL REG. June 29, 1951	REGISTRAR'S SIGNATURE Edith Whittington	24. FUNERAL DIRECTOR Wastler Funeral Home, 301 East Capitol Street, Washington, D.C.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

595916

RECEIVED

1 1951.

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06103

Reg. Dist. No. 218

1. PLACE OF DEATH- COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gaithersburg, Rural</u> LENGTH OF STAY (in this place) <u>18Mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gaithersburg, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Md,</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Leo</u> (Middle) <u>Harper</u> (Last) <u>Harper</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>7</u> (Year) <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Mar 10/1887</u>
9. AGE last birthday <u>64</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of present life, even if retired) <u>Refrigerator At Gas Station</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D C,</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13. FATHER'S NAME <u>Franklin Harper</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Finley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Howard Harper, Gaithersburg, Md,</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>terminal phase 10 days</u> <u>7 years</u>
Immediate cause (a) <u>Arteriosclerotic Heart Disease</u>		
Antecedent cause(s) (b) <u>manifested by angina pectoris, congestive heart failure.</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes Mellitus</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1951, to June 7, 1951, that I last saw the deceased alive on June 7, 1951, and that death occurred at 8:25 p. m., from the causes and on the date stated above.

SIGNATURE Jack Schumacher M.D. ADDRESS Gaithersburg, Md. DATE SIGNED June 8, 1951

23. BURIAL, CREMATION, REMOVAL, etc. DATE 6/10/51 NAME OF CEMETERY OR CREMATORY Forest Oak. LOCATION (City, town, or county) Gaithersburg, Md. (State)

DATE REC'D BY LOCAL REG. June 8, 1951 REGISTRAR'S SIGNATURE Abigail G. Cooke 24. FUNERAL DIRECTOR Ernest C. Gartner, Gaithersburg, Md. ADDRESS

970668

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 115

RECEIVED
JUN 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06104

215

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital		STREET ADDRESS (If rural, give location) 1016 Hamlin Street, N.E.	
3. NAME OF DECEASED (First) Weston (Middle) Welford (Last) HAWKINS		4. DATE OF DEATH (Month) June (Day) 22 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 15, 1887
9. AGE last birthday 63 yrs. 08 Months 07 Days		If under 1 year 08 Months 07 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post office Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Richard HAWKINS		14. MOTHER'S MAIDEN NAME Rosa FORD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Wife: Mary Lillian HAWKINS		18. MEDICAL CERTIFICATION Same as item # 2	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Cerebral hemorrhage due to**

INTERVAL BETWEEN ONSET AND DEATH

2 hrs

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **hypertension**(c) **Arteriosclerosis****2 yrs**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Purpura hemorrhagica**2 days**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial**June 26, 1951****Arlington National****Arlington, Virginia**

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 22, 1951**Edith Whittington****W. E. Jarvis Funeral Home, 1432 U Street, NW, Washington, D.C.**

390906

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06105

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>1618 Good Hope Road, S.E.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>HEBERT</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>13</u> (Year) <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 6, 1951</u>
9. AGE last birthday <u>00</u> yrs. <u>01</u> Months <u>07</u> Days		10. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas B. HEBERT</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy T. COTE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>- - - - -</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>Mother: Dorothy T. HEBERT</u>		18. MEDICAL CERTIFICATION <u>Same as item # 2</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Hydrocephalus & Meningocele</u>			<u>Birth</u>
Antecedent cause(s) (b) <u>752X</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>157a</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 10</u> , 19 <u>51</u> , to <u>June 13</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>51</u> , and that death occurred at <u>5:55</u> P.m., from the causes and on the date stated above.			
SIGNATURE <u>L. W. Sederstrom</u> (Degree or title)		ADDRESS <u>U.S. NAVAL HOSPITAL, BETHESDA, MD.</u> DATE SIGNED <u>June 14, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 18, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
DATE REC'D BY LOCAL REG <u>June 14, 1951</u>	REGISTRAR'S SIGNATURE <u>Elmer Whittington</u>	24. FUNERAL DIRECTOR <u>Chevy-Chase Funeral Home, 5101 Wisconsin Avenue, NW, Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS (AT)

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06106

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lakema Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San & Hospital</u>		STREET ADDRESS (If rural, give location) <u>605 Woodside Pkwy.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Franklin</u> <u>Valentine</u> <u>Hillyard</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6</u> <u>13</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>7-26-64</u>
9. AGE last birthday <u>86</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin F. Hillyard</u>		14. MOTHER'S MAIDEN NAME <u>Rose Sauter</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Ms. Theresa Hillyard 605 Woodside Pkwy N. Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

450.0
93d

(a) Longestive Heart Failure
(b) Terminal uremia
(c) Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

3 yrs.
3 days.
20 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1938, 1951, to June 13, 1951, that I last saw the deceased

alive on June 13, 1951, and that death occurred at 8:20 P m., from the causes and on the date stated above.

SIGNATURE Jenneth Daugherty (Degree or title) ADDRESS 8252 Bayview Ave Silver Spring Md DATE SIGNED 6-13-51

23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/14/51</u>	<u>St. Olaf Cemetery</u>	<u>Washington, D.C.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6/14/51</u>	<u>Francis Gatter</u>	<u>James Hagan Inc.</u>	<u>317 Pa. Ave. S.E.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 13 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06107

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hyattsville, Kent Village</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS <u>7356 Forest Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>(none) (none) HOBBS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 10, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 9, 1951</u>
9. AGE last birthday <u>00</u> yrs. <u>00</u> Months <u>01</u> Days		10. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Cecil H. HOBBS</u>		14. MOTHER'S MAIDEN NAME <u>Patty Marie KEES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Father: Cecil H. HOBBS</u>		18. MEDICAL CERTIFICATION <u>Same as item # 2</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Atelectasis</u>			
Antecedent cause(s) (b) <u>Prematurity (430 gms)</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>---</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 9</u> , 19 <u>51</u> , to <u>June 10</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>June 10</u> , 19 <u>51</u> , and that death occurred at <u>2:53</u> A.m., from the causes and on the date stated above.			
SIGNATURE <u>A. Gedarovich</u>		ADDRESS <u>U.S. NAVAL HOSPITAL, BETHESDA, MD.</u>	
A. GEDAROVICH, LT, MC, USN		June 11, 1951	
23. BURIAL, CREMATION, DISPOSAL (Specify) <u>DISPOSAL</u>		DATE THEREOF <u>June 11, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>USN Medical School</u>		LOCATION (City, town, or county) (State) <u>Bethesda, Maryland.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>June 11, 1951</u>		24. FUNERAL DIRECTOR <u>None</u>	

2060 9126 4240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUN 19 1951

BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06108

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
TOWN <u>39 YEARS</u>		TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HORNER'S Lane</u>		STREET ADDRESS (If rural give location) <u>170 KARAS Lane</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>FREDRICK</u>	(Middle) <u>MANNING</u>	(Last) <u>HOWARD</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	4. DATE OF DEATH (Month) <u>6</u> (Day) <u>12</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	8. DATE OF BIRTH <u>Sept 24, 1873</u>
13. FATHER'S NAME <u>William Howard</u>		9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
17. INFORMANT <u>HELEN DUFFIN, daughter</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>congestive Heart Failure</u>			<u>1 month</u>
Antecedent cause(s) (b) <u>hypertensive Heart disease</u>			<u>10 YEARS</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 1939, to JUNE 22, 1951, that I last saw the deceased alive on JUNE 22, 1951, and that death occurred at 5:25 A m., from the causes and on the date stated above.

SIGNATURE Walter W. Welch M.D. (Degree or title) ADDRESS Rockville, Md. DATE SIGNED 6/23/51

23. BURIAL, CREMATION (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/24/51</u>	<u>Lincoln Park</u>	<u>Rockville</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>6/24/51</u>	<u>Robert L. Snowden</u>	<u>Robert L. Snowden</u>		

Per. Off. H. V. Lewis Jr.

564246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 28 1961
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06109

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg</u>												
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beallsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brookville, Md</u>												
TOWN <u>Beallsville</u> LENGTH OF STAY (In this place) <u>8 Mo</u>				TOWN <u>Brookville, Md</u>												
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)												
3. NAME OF DECEASED (Type or Print) <u>Frances Lucille</u> (First)		(Middle)		(Last) <u>Hunt</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 17 1951</u>										
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 3-1937</u>		9. AGE last birthday <u>13</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>High School Student</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>										
13. FATHER'S NAME <u>Woodrow Wilson Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Mary E Smith</u>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Mr Woodrow W. Hunt</u>										
18. MEDICAL CERTIFICATION <u>Beallsville, Md</u>																
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH																
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Immediate cause</td> <td style="width: 50%;">(a) <u>Asphyxia by drowning</u></td> <td style="width: 20%;">INTERVAL BETWEEN ONSET AND DEATH <u>mother's death.</u></td> </tr> <tr> <td>Antecedent cause(s)</td> <td>(b)</td> <td></td> </tr> <tr> <td>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</td> <td>(c)</td> <td></td> </tr> </table>								Immediate cause	(a) <u>Asphyxia by drowning</u>	INTERVAL BETWEEN ONSET AND DEATH <u>mother's death.</u>	Antecedent cause(s)	(b)		Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
Immediate cause	(a) <u>Asphyxia by drowning</u>	INTERVAL BETWEEN ONSET AND DEATH <u>mother's death.</u>														
Antecedent cause(s)	(b)															
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)															
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.																
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION												
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Farm.</u> (CITY OR TOWN) <u>Beallsville</u> (COUNTY) <u>Montg.</u> (STATE) <u>Md</u>												
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6/ 17/ 51-10A. m.</u>				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Was swimming in pond at home.</u>												
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .																
SIGNATURE <u>Frank J. Brounhart M.D.</u>				ADDRESS <u>Garthland Md</u> DATE SIGNED <u>6-17-51</u>												
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/20/51</u>		NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		LOCATION (City, town, or county) <u>Beallsville, Md</u> (State)										
DATE REC'D BY LOCAL REG. <u>6/21/51</u>		REGISTRAR'S SIGNATURE <u>Charles H. Egan</u>		24. FUNERAL DIRECTOR <u>William B. Hilton</u>		ADDRESS <u>Barnesville, Md</u>										

RECEIVED

JUN 22 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06110 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Eloise</u>	(Middle) <u>McDonald</u>	(Last) <u>Huntley</u>
4. DATE OF DEATH	(Month) <u>JUNE</u>	(Day) <u>20</u>	(Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 15, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>63</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>11/1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W McDonald</u>		14. MOTHER'S MAIDEN NAME <u>Helen Scott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Ashton, Md.</u> <u>Flayd E. Huntley - Mont. Wry</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of sigmoid with

INTERVAL BETWEEN ONSET AND DEATH

8 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Metastasis to small bowel and

(c) Abdominal wall

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

5/18/51

19b. MAJOR FINDINGS OF OPERATION

Listed in course of death

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

A. D. Borriault

M. D.

Sandy Spring, Md.

6/30/51

23. BURIAL CREMATION REMOVAL (Specify)

6/24/51

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

9-22-51

Frances Potter

1756 P AVE NW D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1954
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

061111

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Boonsboro, Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) Rural Route # 2	
3. NAME OF DECEASED (First) John (Middle) Thomas (Last) IRWIN		4. DATE OF DEATH (Month) June (Day) 21 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 23, 1899
9. AGE last birthday 51 yrs. 07 months 28 days		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Businessman		10b. KIND OF BUSINESS OR INDUSTRY Building Material	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George L. IRWIN		14. MOTHER'S MAIDEN NAME Sara WILLAUER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give year or dates of service) WW II		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Wife: May IRWIN			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

Bronchogenic Carcinoma with metastases**5 years**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Feb. 26, 1951**, to **June 21, 1951**, that I last saw the deceased alive on **June 21, 1951**, and that death occurred at **9:10 P.m.**, from the causes and on the date stated above.

(SIGNATURE) **W. W. Kaelber**

(Degree or title)

ADDRESS

DATE SIGNED

W. W. Kaelber, LTJG, MCR, USNR U.S. NAVAL HOSPITAL, BETHESDA, MD. June 22, 1951

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF June 26, 1951	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) Arlington, Virginia	(State)
DATE REC'D BY LOCAL REG June 22, 1951	REGISTRAR'S SIGNATURE Edith Whittington	24. FUNERAL DIRECTOR ADDRESS R. A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290246

RECEIVED
JUN 25 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06112

1. PLACE OF DEATH- COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE New York COUNTY Broome CITY (If outside corporate limits, write RURAL and give nearest town) Johnson City TOWN STREET ADDRESS (If rural, give location) 1 Downs Avenue	
3. NAME OF DECEASED (Type or Print) Stephen John JACOBS		4. DATE OF DEATH June 25, 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec. 8, 1911
9. AGE last birthday 39 yrs. 06 mos. 17 days		10. If under 1 year 06 mos. 17 days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Petty Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George JACOBS		14. MOTHER'S MAIDEN NAME Elizabeth JURUS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war, or dates of service) NW II		16. SOCIAL SECURITY NO. ---	
17. INFORMANT AND ADDRESS U. S. Naval Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Leukemia, Myelogenous acute**

INTERVAL BETWEEN ONSET AND DEATH

7 mos.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Nov 10**, 19**50**, to **June 25**, 19**51**, that I last saw the deceasedalive on **June 25**, 19**51**, and that death occurred at **8:45 A** m., from the causes and on the date stated above.SIGNATURE **S. R. Mills, Jr.** (Degree or title) ADDRESS DATE SIGNED**S. R. MILLS, Jr., LTJG, MC, USN U. S. NAVAL HOSPITAL, BETHESDA, MD. June 26, 1951**

23. BURIAL CREMATION REMOVAL (Specify) Removal	DATE THEREOF June 26, 1951	NAME OF CEMETERY OR CREMATORY Bednarsky Funeral Home	LOCATION (City, town, or county) Binghamton, New York	(State)
DATE REC'D BY LOCAL REG June 26, 1951	REGISTRAR'S SIGNATURE Edith [Signature]	24. FUNERAL DIRECTOR ADDRESS Wastler Funeral Home, 301 East Capitol Street, Washington, D.C.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 15

BURNED V. S.

JUN 27 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06113

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
TOWN <u>Suburban Hospital</u>		TOWN <u>Washington D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>3861 Porter St. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Virginia</u>	(Middle) <u>B</u>	(Last) <u>Johns</u>
6. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>1-9-1859</u>
9. AGE last birthday <u>92</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	12. CITIZENSHIP OF WHAT COUNTRY <u>U.S.</u>
13. FATHER'S NAME <u>James Colegrove</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT AND ADDRESS <u>Lucille M. Nichols - home address #2</u>	18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

INTERVAL BETWEEN ONSET AND DEATH

YEARS

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

NONE

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 1950, to June 18, 1951, that I last saw the deceased

alive on June 18, 1951, and that death occurred at 8:12 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. Witt E. De Laury, M.D. 7325 ABERDEEN RD. Bethesda, Md. 6/18/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial - Home</u>	<u>6/19/51</u>	<u>Woodland</u>	<u>Van Wert Co., Ohio</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6/19/51</u>	<u>Bessie M. Thompson</u>	<u>Robert A. Humphrey</u>	<u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 1-4

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06114

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery Co. Gen.</u>		STREET ADDRESS (If rural, give location) <u>RFD #4</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>IVY</u>	(Middle) <u>MAYBELLE</u>	(Last) <u>JOHNSON</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 24, 1905</u>
9. AGE last birthday <u>46</u> yrs.		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>20</u> (Year) <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>xxx</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. Ricketts</u>		14. MOTHER'S MAIDEN NAME <u>Bessie May Selby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Edward Johnson-RFD #4 Rockville, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause		(a) <u>CEREBRAL HEMMORHAGE</u>	<u>3 DAYS</u>
Antecedent cause(s)		(b) <u>CONGESTIVE HEART FAILURE</u>	<u>FIVE YEARS</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>	<u>12 YEARS</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN, 1949, to JUNE 20, 1951, that I last saw the deceased alive on JUNE 20, 1951, and that death occurred at 11:10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Gordon S. Rosenberg M.D. Rockville, Md. 6/20/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/22/51</u>	<u>Forest Oak Cemetery</u>	<u>Gaithersburg Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6-21-51</u>	<u>Gertrude B. Lawler</u>	<u>Robert A. Humphrey</u>	<u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06115 214

1. PLACE OF DEATH: COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
TOWN <u>SILVER SPRING</u>				TOWN <u>SILVER SPRING</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>224 Williamsburg Drive</u>				STREET ADDRESS (If rural, give location) <u>224 WILLIAMSBURG DRIVE</u>			
3. NAME OF DECEASED (Type or Print) <u>MADGE</u>		(First) <u>H.</u> (Middle) <u>Jones</u> (Last)		4. DATE OF DEATH <u>June 11</u>		(Month) (Day) (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WID</u>		8. DATE OF BIRTH <u>Sept 24 1884</u>	
9. AGE last birthday <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George Salt</u>			
14. MOTHER'S MAIDEN NAME <u>Sallie Johnson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>			
16. SOCIAL SECURITY No. <u>None</u>				17. INFORMANT AND ADDRESS <u>MRS RUBI Lee (DAUGHTER)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Cardiac decompensation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs</u>			
Antecedent cause(s) (b) <u>Hypertension</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>11 Hypertension</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20 May</u> , 19 <u>51</u> , to <u>11 June</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>8 June</u> , 19 <u>51</u> , and that death occurred at <u>1:30 A.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>William D. Cud m d</u>				ADDRESS <u>Silver Spring</u> DATE SIGNED <u>11 June 51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>6-13-1951</u>		NAME OF CEMETERY OR CREMATORY <u>MT TABOR Cemetery S.C.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>6/12/51</u>		REGISTRAR'S SIGNATURE <u>Frances Geller</u>		24. FUNERAL DIRECTOR <u>W. WILLIAM Lee's Sons Co</u>		ADDRESS <u>300 - 4th ST. N.E. WASHINGTON, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06116

Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethersburg</u> TOWN <u>Bethersburg</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethersburg</u> TOWN <u>Bethersburg</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Robert</u> (Middle) <u>Theodore</u> (Last) <u>Keys</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, - WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 28, 1903</u>
9. AGE last birthday <u>48</u> yrs. If under 1 year Months Days Hours Min.		10. AGE last birthday <u>48</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OR WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther Keys</u>		14. MOTHER'S MAIDEN NAME <u>Selen L. Keys</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Selen L. Keys</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary occlusion</u>		
Antecedent cause(s) (b) <u>420.1</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) <u>Frank J. Brochert M.D.</u>		ADDRESS <u>Yanithsburg Md</u>		DATE SIGNED <u>6-13-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>6/17/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Zion</u>	LOCATION (City, town, or county) <u>St. Zion, Md</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>June 16, 1951</u>	REGISTRAR'S SIGNATURE <u>Charles G. Cooke</u>	24. FUNERAL DIRECTOR <u>Robert L. Swarode</u>	ADDRESS <u>Rockville, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1951
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06117

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Morningside	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 23 Marianne Drive	
3. NAME OF DECEASED (Type or Print) James Russell		4. DATE OF DEATH (Month) June (Day) 22 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH June 20, 1951
9. AGE last birthday 00 yrs. 00 months 02 days		10. CITIZEN OF WHAT COUNTRY? US	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles J. KIKER		14. MOTHER'S MAIDEN NAME Joan Marguerite WISE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---	
17. INFORMANT AND ADDRESS Father: Charles J. KIKER			

18. MEDICAL CERTIFICATION

Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Immaturity

Antecedent cause(s)

(b)

Prematurity

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **June 20, 1951**, to **June 22, 1951**, that I last saw the deceased alive on **June 22, 1951**, and that death occurred at **7:35 A.m.**, from the causes and on the date stated above.

SIGNATURE *L. W. Sederstrom* (Degree or title) ADDRESS DATE SIGNED**L. W. SEDERSTROM, LT, MC, USN U.S. NAVAL HOSPITAL, BETHESDA, MD. June 22, 1951**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	June 25, 1951	Arlington, National	Arlington, Virginia	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
June 22, 1951	<i>Edith Whittington</i>	R. A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland.		

216201203312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 25 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06118

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) Bethesda, Rural LENGTH OF STAY (in this place) 1 day HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince Georges CITY (If outside corporate limits, write RURAL and give nearest town) Morningside STREET ADDRESS (If rural, give location) 23 Marianne Drive	
3. NAME OF DECEASED (First) William (Middle) Daniel (Last) KIKER <i>Twin #1</i>		4. DATE OF DEATH (Month) June (Day) 21 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH June 20, 1951
9. AGE last birthday 00 yrs. 00 months 01 days		10. If under 1 year If under 24 hrs. Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles J. KIKER		14. MOTHER'S MAIDEN NAME Joan Marguerite WISE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT AND ADDRESS Father: Charles J. KIKER		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Immaturity			
Antecedent cause(s) (b) Prematurity			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) ---			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 20 , 19 51 , to June 21 , 19 51 , that I last saw the deceased alive on June 21 , 19 51 , and that death occurred at 4:08 A m., from the causes and on the date stated above.			
SIGNATURE L. W. SEDERSTROM, LT, MC, USN (Degree or title)		ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD. DATE SIGNED June 21, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF June 25, 1951 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) (State) Arlington, Virginia			
DATE REC'D BY LOCAL REG. June 21, 1951 REGISTRAR'S SIGNATURE Edith Whittington		24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland.	

206201202 311

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be exact as to age and sex. Especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06119

CERTIFICATE OF DEATH

Reg. Dist. No. **119**

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD COUNTY P. Geo. District of Columbia	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Washington - Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital		STREET ADDRESS (If rural, give location) 4910 Deal Drive, S. E.	
3. NAME OF DECEASED (First) Jimmie (Middle) Lorraine (Last) KLEPPER		4. DATE OF DEATH (Month) June 11, (Day) 1951 (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH June 4, 1919
9. AGE last birthday 32 yrs.		10. If under 1 year Months 00 Days 07 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Jim GLENNING		14. MOTHER'S MAIDEN NAME Evelyn WINN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - -		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Husband: Homer C. KLEPPER			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Pylonephritis, Chronic****25 yrs.**

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Yetero-Colonic fistula, acquired, for Congenital****32 yrs.**(c) **extrophy of the bladder.**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **May 31**, 19 **51**, to **June 11**, 19 **51**, that I last saw the deceasedalive on **June 11**, 19 **51**, and that death occurred at **1:20 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. McCarthy, Lt. MC, USN U.S. NAVAL HOSPITAL, BETHESDA, MD. June 11, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Removal	June 11, 1951	Celina Cemetery	Celina, Texas	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
June 11, 1951	Blair Whittington	Chevy Chase Funeral Home	5101 Wisconsin Avenue, NW, Washington, D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A151

RECEIVED
JUN 13 1951
BUREAU V. S.

Evidence for change of serial
number shown on Film MARYLAND STATE DEPARTMENT OF HEALTH
G135 9/13/51 dm.

06471

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 2/7

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write OR give nearest town) <u>Brockton</u> TOWN <u>Brockton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brockton Dam</u>		MARYLAND LENGTH OF STAY (In this place) <u>1/2 day</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY CITY (If outside corporate limits, write OR give nearest town) TOWN <u>Washington</u> STREET ADDRESS (If rural, give location) <u>1624 St. N.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>Johnny Robert Korbler</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>June 23 1957</u> (Month) (Day) (Year)			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>7-21-30</u>	9. AGE last birthday <u>20</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
13. FATHER'S NAME <u>Frank Korbler</u>		14. MOTHER'S MAIDEN NAME <u>AF 14 276 397</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>present</u>		16. Social Security No. <u>Serial No. AF 2476347</u>		17. INFORMANT AND ADDRESS <u>Brockton Mail records</u>	
18. MEDICAL CERTIFICATION <u>Bolling</u>					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <u>Asphyxiation by drowning</u>					
Antecedent cause(s) (b) <u>sudden death</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg, etc.) <u>Brockton Dam</u>		(CITY OR TOWN) <u>Brockton</u>	(COUNTY) <u>Montg</u> (STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-23-57 - 3:30 P.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>drowned while swimming</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
SIGNATURE <u>Frank J. Brochart M.D.</u>		(Degree or title)		ADDRESS <u>Gaithersburg MD</u>	
DATE SIGNED <u>6-23-57</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>6-23-57</u>		NAME OF CEMETERY OR CREMATORY	
LOCATION (City, town, or county) (State)					
DATE REC'D BY LOCAL REG. <u>6-23-57</u>		REGISTRAR'S SIGNATURE <u>Esther B. Lawler</u>		24. FUNERAL DIRECTOR <u>Westler Funeral Home</u>	
				ADDRESS <u>Washington D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06120

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>4712 Cortland Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Alice</u> (Middle) <u>Graham</u> (Last) <u>LAKE</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 21, 1893</u>
9. AGE last birthday <u>57</u> yrs. <u>09</u> Months <u>13</u> Days		10. CITIZEN OF WHAT COUNTRY? <u>US(N)</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US(N)</u>	
13. FATHER'S NAME <u>William GRAHAM</u>		14. MOTHER'S MAIDEN NAME <u>Margaret COLVILLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS <u>Brother-in-law: R. L. HICKS.</u>			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) CARCINOMA OF RIGHT BREAST2 yr

Antecedent cause(s)

(b) WITH GENERALIZED

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) METASTASESII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>10/50</u>		19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA OF BREAST & AXILLARY METASTASES</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Apr. 9, 1951, to June 4, 1951, that I last saw the deceased alive on June 4, 1951, and that death occurred at 3:00 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

P. Trautman
P. TRAUTMAN, LTJG, MCR, USNR U.S. NAVAL HOSPITAL, BETHESDA, MD. June 4, 1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>June 4, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Fort Rosecrans</u>	LOCATION (City, town, or county) (State) <u>San Diego, California</u>
--	-------------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>June 4, 1951</u>	REGISTRAR'S SIGNATURE <u>Edna Whittington</u>	24. FUNERAL DIRECTOR <u>R. A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland.</u>
---	--	--

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY			
CITY (If outside corporate limits, write RURAL and OR give nearest town) Bethesda, Rural				CITY (If outside corporate limits, write RURAL and give nearest town) Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural, give location) 6 Starboard Green, S.W.			
3. NAME OF DECEASED (First) Rosemary		(Middle) (none)		(Last) LANGSTON		4. DATE OF DEATH (Month) June 30, (Day) 19 (Year) 51	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH June 27, 1951	
9. AGE last birthday 00 yrs.		If under 1 year Months 00 Days 03		If under 24 hrs. Hours 03 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Isaac C. LANGSTON				14. MOTHER'S MAIDEN NAME Mary Jane DODRA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---		17. INFORMANT AND ADDRESS Father: Isaac C. LANGSTON	
18. MEDICAL CERTIFICATION Same as item # 2							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) Immaturity							
Antecedent cause(s) (b) Prematurity							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) HOMICIDE		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 27, 1951 , to June 30, 1951 , that I last saw the deceased alive on June 30, 1951 , and that death occurred at 5:00 A. m., from the causes and on the date stated above.							
SIGNATURE L. W. SØDERSTROM (Degree or title)				ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.		DATE SIGNED June 30, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF July 2, 1951		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) Suitland, Maryland.	
DATE REC'D BY LOCAL REG. June 30, 1951		REGISTRAR'S SIGNATURE Edith Whittington		24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home,		ADDRESS 7557 Wisconsin Avenue, Bethesda, Maryland.	

206271322280

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

06122

1. PLACE OF DEATH- COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE WASHINGTON, D.C.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) ROCKVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS CHESTNUT LODGE		STREET ADDRESS (If rural, give location) 500 W. MONTGOMERY AVE.	
3. NAME OF DECEASED (Type or Print) (First) FRANCES (Middle) KIMBALL (Last) LAY		4. DATE OF DEATH (Month) JUNE (Day) 27 (Year) 1951	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH MAR 23, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) SAVANNAH, GEORGIA		12. CITIZEN OF WHAT COUNTRY? DIST. COL.	
13. FATHER'S NAME RICHARD G. LAY		14. MOTHER'S MAIDEN NAME CAROLINE KIMBALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Cokeran Thomp.		18. ADDRESS 3244 Neptiska Ave NW WASH. D.C.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) *Myocardial infarction*

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Coronary occlusion; coronary sclerosis*(c) *Pulmonary infarction**Renal atherosclerosis*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Diabetes Mellitus; hypertension

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) **INJURY**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **JUNE 18, 1951**, to **JUNE 27, 1951**, that I last saw the deceasedalive on **JUNE 27, 1951**, and that death occurred at **10:31 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Cecil C. H. Cullander M.D. 500 W. Montgomery Ave**Rockville, Md. June 27, 1951**

23. BURIAL, CREMATION

(Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-28-51**Helen A. Eichelberger****Gas. Fowler's Son 1756 Pa Ave NW Wash. D.C.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU U. S.

JUN 25 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06123

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ohio</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dayton</u>	
TOWN <u>Suburban Hospital</u>		TOWN <u>Dayton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>1918 Benson Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>Belle</u>	(Last) <u>Lehman</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>12</u>	(Year) <u>1951</u>
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>4-23-88</u>
9. AGE last birthday <u>70</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Beard</u>		14. MOTHER'S MAIDEN NAME <u>Susanna Stoudt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>Mary B. Lehman</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pulmonary embolism (left)</u>	<u>sudden</u>
Antecedent cause(s) (b) <u>Chronic pneumonia</u>	<u>1 week</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pleural effusion</u>	<u>20 days</u>
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH	PLACE (Home, farm, factory, street, office, etc.) <u>Highway</u>	(CITY OR TOWN) <u>near Gaithersburg</u> (COUNTY) <u>Montg</u> (STATE) <u>md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 22-51-5:45 P.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Auto accident</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Frank J. Brummett M.D.</u>	DATE SIGNED <u>6-12-51</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	NAME OF CEMETERY OR CREMATORY
<u>Burial-transit</u>	<u>John Morris Funeral Home</u>
DATE REC'D BY LOCAL REG. <u>6/12/51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>
24. FUNERAL DIRECTOR	ADDRESS
<u>Robert A. Humphrey</u>	<u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUN 15 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06124

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1305 Ballard St.</u>		STREET ADDRESS (If rural, give location) <u>1305 Ballard St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Daryl</u> <u>Dee</u> <u>Leslie</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 14</u> <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Aug. 16, 1949</u>
9. AGE last birthday <u>1</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Frank G. Leslie</u>		14. MOTHER'S MAIDEN NAME <u>Darrell Hobough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Dr. Frank G. Leslie, 1305 Ballard St.</u>	
17. INFORMANT AND ADDRESS <u>Dr. Frank G. Leslie, 1305 Ballard St.</u>		18. MEDICAL CERTIFICATION <u>Silver Spring, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

200.2 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Asphyxia - Cardiac Failure
(b) Pleural Effusion, Thyroid Hypertrophy
(c) Leuco - Sarcoma

INTERVAL BETWEEN ONSET AND DEATH

Comment

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	<u>May 25 1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 25, 1951, to June 14, 1951 that I last saw the deceased alive on June 14, 1951, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Trans. & Burial</u>	DATE THEREOF <u>6/16/51</u>	NAME OF CEMETERY OR CREMATORY <u>Butler County</u>	LOCATION (City, town, or county) <u>Pa.</u>
DATE REC'D BY LOCAL REG <u>6/18/51</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Wm. B. Humphrey</u>	ADDRESS <u>8434 Georgia Ave. Silver Spring, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED
JUN 21 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06125

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Glen Echo Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hospital</i>		STREET ADDRESS (If rural, give location) <i>7011 MacArthur Blvd.</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Annie</i> (Middle) <i>Teresa</i> (Last) <i>Lewis</i>		4. DATE OF DEATH (Month) <i>June</i> (Day) <i>30</i> (Year) <i>1951</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u> (Specify)	8. DATE OF BIRTH <i>Jan. 30 1882</i> 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Proprietor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery store</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT AND ADDRESS <i>Joseph Lewis 7035 Weehawken Rd. Wash. 16 D.C.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <i>Congestive Heart Failure</i>		<i>15 hours</i>
Antecedent cause(s) (b) <i>Cerebral Thrombosis</i>		<i>15 hours</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Arteriosclerosis, general and Cerebral</i>		<i>10 years</i>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>None</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <i>SUICIDE</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Sept.*, 1949, to *June 30*, 1951, that I last saw the deceased alive on *June 30*, 1951, and that death occurred at *5:50 P.* m., from the causes and on the date stated above.

SIGNATURE <i>Robert G. Angle</i> (Degree or title) <i>M.D.</i>	ADDRESS <i>106 Del Ray Ave Bethesda Maryland</i>	DATE SIGNED <i>June 30 1951</i>
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>July 3, 1951</i>	NAME OF CEMETERY OR CREMATORY <i>Western</i>
LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>Maryland</i>	
DATE REC'D BY LOCAL REG. <i>7/2/51</i>	REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	24. FUNERAL DIRECTOR <i>Robert A. Humphrey</i>
	ADDRESS <i>Bethesda, Md.</i>	

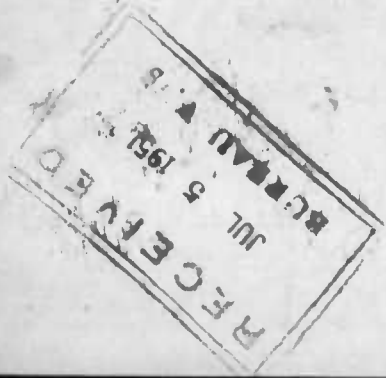
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-415

290636

Wi 1886
Joseph Davis



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06126

Reg. Dist. No. 211

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Cedar Grove</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural, Cedar Grove, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Cedar Grove, Md.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lillian</u>	(Middle) <u>E</u>	(Last) <u>Liller</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5/22/1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic-own home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>71</u> yrs.
13. FATHER'S NAME <u>Louis Simon</u>		11. BIRTHPLACE (State or foreign country) <u>Elkins, West Virginia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <u>Emily B. Douglas</u>	
17. INFORMANT <u>Mrs. Maurice Johnson</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of gall-bladder with generalized metastases 1 year.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 3, 1951, to June 5, 1951, that I last saw the deceased alive on June 5, 1951, and that death occurred at 6:15 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/7/51</u>	<u>Baptist Cemetery</u>	<u>Cedar Grove, Maryland</u>	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>June 7, 1951</u>	<u>Della K. Burdette</u>	<u>W. W. Barber</u>	<u>Laytonsville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2731

06127
214

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>MONT.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12 years</u>		STREET ADDRESS (If rural, give location) <u>7721 Eastern Ave. N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>EDNAH</u> (First) <u>FAIRFAX</u> (Middle) <u>LONG</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-14-1882</u>
9. AGE last birthday <u>68</u> yrs.		10. If under 1 year: Months <u>6</u> Days <u>13</u> Hours <u>19</u> Min. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Yates</u>		14. MOTHER'S MARRIED NAME <u>Lillie Graham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Frank S. Long 7721 Eastern Ave. N.W.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

6 mos.

Antecedent cause(s)

(b) Arteriosclerosis2 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Myocardial infarction6 mos.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6/11, 1951, to 6/13, 1951, that I last saw the deceasedalive on 6/11, 1951 and that death occurred at 7 A m., from the causes and on the date stated above.SIGNATURE Sanford J. Randall, MD. ADDRESS 7730 Eastern Ave. N.W. DATE SIGNED 6/13/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/15/51</u>	<u>Arlington National</u>	<u>St. Myer Virginia</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/13/51</u>	<u>Frances Potter</u>	<u>The S. H. Jones Co. 2901-14 St. N.W.</u>	<u>Washington 9 D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

BUREAU V. S.

JUN 15 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

06128

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223 -

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
TOWN <u>16 CRESCENT PLACE,</u>		TOWN <u>16 CRESCENT PL.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Rosa D. Mann</u>		4. DATE OF DEATH <u>June 20, 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG 29, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE last birthday <u>74</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTH PLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SCHUMANN</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>DOROTHEA M. FISCHER, 9400 SAYBROOK AVE, SILVER SPRING, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause		(a) <u>Chronic myocarditis</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <u>Acute Cardiac failure</u>	
(c) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Undetermined</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis generalized</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 1, 1950</u> , to <u>June 20, 1951</u> , that I last saw the deceased alive on <u>June 20, 1951</u> , and that death occurred at <u>2:35 A.M.</u> , from the causes and on the date stated above.		23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	
DATE REC'D BY LOCAL REG. <u>6-20-51</u>		DATE THEREOF <u>JUNE 23, 1951</u>	
REGISTRAR'S SIGNATURE <u>J. H. DODD</u>		NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u>	
24. FUNERAL DIRECTOR <u>James J. Talley</u>		LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>	
ADDRESS <u>254 CARROLL ST. N.W.</u>		ADDRESS <u>TAKOMA PARK 12, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

BUREAU V. S.

JUN 22 1951

RECEIVED

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

MARGIN RESERVED FOR BINDING

VS. A151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>St. Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TAKOMA PARK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>MT Rainier</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 BALTIMORE AVE</u>		STREET ADDRESS <u>7205 Queens Chapel Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>DORA</u>		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>APR 6, 1874</u>	
9. AGE last birthday <u>77</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>TOM ROBERTSON</u>		14. MOTHER'S MAIDEN NAME <u>PATTERSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>MRS. HAROLD H. MORRIS, 2705 QUEENS CHAPEL RD.</u>		18. MEDICAL CERTIFICATION <u>MT. RAINIER, MD.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Thrombosis, Cerebral</u>		<u>30 hrs.</u>	
(b) Antecedent cause(s) <u>Arteriosclerosis</u>		<u>5 yrs</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9/2</u> , 19 <u>48</u> , to <u>June 4</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>51</u> , and that death occurred at <u>8:53 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Ans Smith MD</u>		ADDRESS <u>4601 16th St NW Wash. D.C.</u> DATE SIGNED <u>6/4/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June 6, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>RUFFIN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>REIDSVILLE, ROCKINGHAM CO. N. CAR.</u>	
DATE REC'D BY LOCAL REG. <u>6-4-51</u>		24. FUNERAL DIRECTOR <u>Donna Stalling</u> ADDRESS <u>254 Carroll St. N. W. Takoma Park 12, D.C.</u>	

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06130

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda,		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital		STREET ADDRESS (If rural, give location) 2422 Dexter Ave.	
3. NAME OF DECEASED (Type or Print) Alice Gray		4. DATE OF DEATH (Month) June (Day) 15 (Year) 19 51	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 20, 1870
9. AGE last birthday 80 yrs.		10. If under 1 year: Months 0 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Own home	
12. BIRTHPLACE (State or foreign country) Carroll County, Virginia		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME Christian Harriman		15. MOTHER'S MAIDEN NAME Julia Roberson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. none	
18. INFORMANT AND ADDRESS Mrs. Broward Howes, 2422 Dexter Ave.		19. MEDICAL CERTIFICATION Silver Spring, Md.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Diverticulitis, acute

Antecedent cause(s)

(b)

Diverticulosis, Colon

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.**Cardiac failure**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov. 17, 1947**, to **June 15, 1951**, that I last saw the deceasedalive on **June 15, 1951**, and that death occurred at **11:30 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Philip H. Varner, M.D.**Cluny Chase, Md. 6/15/51**23. BURIAL, CREMATION
REMOVAL (Specify)
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

6/18/51**Colesville Cemetery****Montgomery County, Md.**

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/18/51**Bessie M. Thompson****Warren B. Pumphrey****8434 Ga. Ave.****Silver Spring, Maryland**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-T

RECEIVED

JUN 20 1961

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06131

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>US 29 Sokesville, Md.</u> LENGTH OF STAY (in this place) <u>2 yrs. 4m.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>University Park, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Jolliffe Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>4308 Claggett Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>SANILLA</u> (First) <u>SOOLEY</u> (Middle) <u>Mc MILLAN</u> (Last)		4. DATE OF DEATH <u>June 14</u> (Month) <u>1957</u> (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>12/17/72</u>
9. AGE <u>78</u> yrs. <u>12</u> months <u>1</u> year <u>1</u> day <u>1</u> hour <u>1</u> min.		10. AGE last Birthday	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTH PLACE (State or foreign country) <u>MACON, GA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DEL SOOLEY</u>		14. MOTHER'S MAIDEN NAME <u>Katherine PARPello</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>R. P. Mc MILLAN</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Heart Attack</u>		<u>8 hrs</u>
Antecedent cause(s)	(b) <u>Thrombosed atherosclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>None</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
HOMICIDE	INJURY		(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 2, 1949 to June 14, 1957, that I last saw the deceasedalive on June 13, 1957, and that death occurred at 4:20 m., from the causes and on the date stated above.SIGNATURE Dr. R. P. McMillan (Degree or title) ADDRESS 1008 Luminary Rd., Silver Spring, Md. DATE SIGNED 6-14-57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>6/16/57</u>	NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem.</u>	LOCATION (City, town, or county) <u>Washington, D.C.</u> (State)
DATE REC'D BY LOCAL REG <u>6/15/57</u>	REGISTRAR'S SIGNATURE <u>Francis Potter</u>	24. FUNERAL DIRECTOR <u>F. Gasek's Sons</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPT. OF JUSTICE
RECEIVED

JUN 18 1954

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06132

1. PLACE OF DEATH- COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY District of Columbia CITY (If outside corporate limits, write RURAL and give nearest town) Washington STREET ADDRESS (If rural, give location) 2009 Wyoming Avenue, NW.	
3. NAME OF DECEASED (First) (none)	(Middle) (none)	(Last) McREE	4. DATE OF DEATH (Month) June (Day) 21 (Year) 19 51
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH June 20, 1951
9. AGE last birthday 00 yrs. 00 Months 00 Days 00 Hours 00 Mins. 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William H. McREE		14. MOTHER'S MAIDEN NAME Pauline TALLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Father: William H. McREE		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) CONGENITAL HYDROCEPHALUS WITH SPINA BIFIDA			
Antecedent cause(s) (b) 752X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 157a			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 20 , 19 51 , to June 21 , 19 51 , that I last saw the deceased alive on June 21 , 19 51 , and that death occurred at 12:35 A .m., from the causes and on the date stated above.			
SIGNATURE C. H. GILLILAND		ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
DATE SIGNED June 22, 1951			
23. BURIAL, CREMATION, DISPOSAL (Specify) Disposal		DATE THEREOF June 22, 1951	
NAME OF CEMETERY OR CREMATORY USN Medical School		LOCATION (City, town, or county) Bethesda, Maryland.	
24. FUNERAL DIRECTOR None		ADDRESS	

206301361363

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. S.

JUN 25 1961

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06133

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Dinwiddie</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Petersburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>437 Harrison Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Ocie</u> <u>Butler</u> <u>MORRISON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 11,</u> <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 23, 1873</u>
9. AGE last birthday <u>77</u> yrs.		10. If under 1 year 10ths 100ths 1000ths <u>06</u> <u>10</u> <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not known</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George MORRISON</u>		14. MOTHER'S MAIDEN NAME <u>Ella WOLF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Wife: Mrs. O. C. MORRISON</u>			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Arteriosclerotic Heart Disease

Antecedent cause(s)

(b) Atherosclerosis, generalized(c) 420.0
93d
Disease or conditions, if any, giving rise to the above cause stating the underlying cause lastII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 7, 1951, to June 11, 1951, that I last saw the deceasedalive on June 11, 1951, and that death occurred at 6:27 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. R. REYNOLDS, LTJG, MCR, USNR U.S. NAVAL HOSPITAL, BETHESDA, MD. June 11, 1951

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>June 11, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Blanford Cemetery</u>		LOCATION (City, town, or county) (State) <u>Petersburg, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>June 11, 1951</u>		REGISTRAR'S SIGNATURE <u>Edith Whittington</u>		24. FUNERAL DIRECTOR <u>Hysong Funeral Home, 1300 N Street,</u>		ADDRESS <u>NW, Washington, D. C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 13 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06134

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SILVER SPRING</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SILVER SPRING</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>9503 ST. ANDREWS WAY</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>FRANK</u> (Middle) <u>H</u> (Last) <u>MURPHY</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 18, 1896</u>
9. AGE last birthday <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRUGGIST</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRUGGIST</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL J. MURPHY</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE ALLEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>195-01-6792</u>	
17. INFORMANT AND ADDRESS <u>CHARLOTTE DEUNE MURPHY</u>		18. MEDICAL CERTIFICATION <u>9503 ST. ANDREWS WAY SILVER SPRING, MD.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of pancreas

INTERVAL BETWEEN ONSET AND DEATH

18 mo.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 1, 1950, to June 11, 1951, that I last saw the deceased alive on June 10, 1951, and that death occurred at 3:50 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Chas. J. Carole M.D.6801-6th St. N.W. Wash. D.C.6/11/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>JUNE 14/51</u>	<u>Calvary Cemetery</u>	<u>Altoona</u>	<u>Penn.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/12/51</u>	<u>Frances Collet</u>	<u>Francis J. Collins</u>	<u>3821-14th St. N.W. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-25

RECEIVED

JUN 14 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06135

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 3569 Bensinger Road	
3. NAME OF DECEASED (Type or Print) Frederick William MYERS		4. DATE OF DEATH June 28, 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH June 28, 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	9. AGE last birthday 00 yrs. 00 months 00 days 01 hours 02 min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Melvin F. MYERS		14. MOTHER'S MAIDEN NAME Beatrice EARLINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS Father: Melvin F. MYERS		18. MEDICAL CERTIFICATION Same as item # 2	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) 762.0 Antecedent cause(s) <i>Cholelithiasis Congenital</i> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 161a (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 28, 1951 , to June 28, 1951 , that I last saw the deceased alive on June 28, 1951 , and that death occurred at 3:45 P.m. , from the causes and on the date stated above.			
SIGNATURE <i>A. Gedarovich</i> A. GEDAROVICH, LT, MC, USN		ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD. DATE SIGNED June 29, 1951	
23. BURIAL CREMATION REMOVAL (Specify) Disposal		DATE THEREOF June 29, 1951	
NAME OF CEMETERY OR CREMATORY USN Medical School		LOCATION (City, town, or county) (State) Bethesda, Maryland.	
DATE REC'D BY LOCAL REG. June 29, 1951		REGISTRAR'S SIGNATURE <i>Edith Whittington</i>	
24. FUNERAL DIRECTOR		ADDRESS None.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. ATT

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06136

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 732 Richmond Ave.		STREET ADDRESS (If rural, give location) 732 Richmond Ave.	
3. NAME OF DECEASED (Type or Print) Elizabeth Hoffer Niman		4. DATE OF DEATH (Month) June (Day) 6 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 9, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	9. AGE last birthday 70 yrs.
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Hoffer		14. MOTHER'S MAIDEN NAME Melissa Crider	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Miss Margaret Niman, 732 Richmond Ave.		18. MEDICAL CERTIFICATION Silver Spring, Md.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Lymphosarcoma**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan.**, 19**51**, to **6 June**, 19**51**, that I last saw the deceased

alive on **5 June**, 19**51**, and that death occurred at **12:45 P.**m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) **Trans. & Burial**

DATE THEREOF **6/7/51**

NAME OF CEMETERY OR CREMATORY **Mansfield Cemetery**

LOCATION (City, town, or county) (State) **Mansfield, Ohio**

DATE REC'D BY LOCAL REG. **6/7/51**

REGISTRAR'S SIGNATURE **Francis Potter**

24. FUNERAL DIRECTOR **Warwick Humphrey**

ADDRESS

8434 Ga. Ave. Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

06137

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Wash. D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>2608 Harfield St. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Manda</u>	(Middle) <u>A</u>	(Last) <u>Ogden</u>
4. SEX <u>Female</u>	5. COLOR OR RACE <u>White</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	7. DATE OF BIRTH <u>Nov. 3, 1899</u>
8. AGE last birthday <u>51</u> yrs.	9. If under 1 year Months <u>6</u> Days <u>4</u>	10. If under 24 hrs. Hours <u>24</u> Min.	11. BIRTHPLACE (State or foreign country) <u>Bethesda, Kentucky</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>James L. Ogden</u>	
14. MOTHER'S MAIDEN NAME <u>Lucy Brooks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u>123-45-6789</u>		17. INFORMANT AND ADDRESS <u>James L. Ogden</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>approx. 1 yr.</u>
(a) Immediate cause <u>Cervical Carcinoma - Primary</u>		
(b) Antecedent cause(s) <u>undetermined</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION <u>June 1, 51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Cervical Carcinoma - Primary</u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>INJURY</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 1, 1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>undetermined</u>

22. I hereby certify that I attended the deceased from June 1, 1951, to June 5, 1951, that I last saw the deceased alive on June 3, 1951, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

SIGNATURE James L. Ogden (Degree or title) ADDRESS Kerrington Md 61 51 DATE SIGNED 6/5/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>June 6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	LOCATION (City, town, or county) <u>Suitland, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>6/5/51</u>	REGISTRAR'S SIGNATURE <u>James L. Ogden</u>	24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u>	ADDRESS <u>1756 Pa. Ave. N. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

350454

RECEIVED
JUN 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06138

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) Quarters "D", National Naval Medical Center	
3. NAME OF DECEASED (Type or Print) Walter Edwin OLLEY		4. DATE OF DEATH (Month) June (Day) 29 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 6, 1860
9. AGE last birthday 90 yrs.		10. If under 1 year Months 09 Days 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? US(N)	
13. FATHER'S NAME John E. OLLEY		14. MOTHER'S MAIDEN NAME Catherine COX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. ---	
17. INFORMANT AND ADDRESS Son-in-law: Carl H. McMILLAN		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 154X Metastases to Liver		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
Antecedent cause(s) 46d Adenocarcinoma, Rectum		9 mo	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized anasarca			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	
22. I hereby certify that I attended the deceased from June 26 , 19 51 , to June 29 , 19 51 , that I last saw the deceased alive on June 29 , 19 51 , and that death occurred at 9:09 P. m., from the causes and on the date stated above.			
SIGNATURE R. O. Canada, Jr.		ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
DATE SIGNED June 30, 1951		DATE SIGNED June 30, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) Crementation		DATE THEREOF July 2, 1951	
NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		LOCATION (City, town, or county) (State) Suitland, Maryland.	
DATE REC'D BY LOCAL REG. June 30, 1951		24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AN

290 497



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06139
Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>8208 Kentbridge Dr.</u>	
3. NAME OF DECEASED (Type or Print) <u>Joe</u> (First) <u>Thomas</u> (Middle) <u>Allen</u> (Last)		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 6, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs. If under 1 year: Months <u>10</u> Days <u>14</u> Hours <u>14</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dr. Thomas Craig</u>		14. MOTHER'S MAIDEN NAME <u>Mary Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>No</u>	
17. INFORMANT AND ADDRESS <u>Laila Baden-Daughter</u>		17. INFORMANT AND ADDRESS <u>9114 Fairview Rd. Silver Spring, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Respiratory Failure

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

Antecedent cause(s)

(b)

Arteriosclerosis Coronary Occlusion

3 mo.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Coronary Occlusion

14 hrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/19, 1951, to 6/20, 1951, that I last saw the deceased

alive on 6/19, 1951, and that death occurred at 1:10 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Frank Y. Jagers Jr. M.D.

5707 Wisconsin Ave Chevy Chase Md. 6/20/51

23. BURIAL CREMATION

BURIAL (Specify)

DATE THEREOF 6-22-51

NAME OF CEMETERY OR CREMATORY Nat. Memorial Park

LOCATION (City, town, or county) Falls Church Virginia

(State)

DATE REC'D BY LOCAL REG. 6-20-51

REGISTRAR'S SIGNATURE Bessie M. Thompson

24. FUNERAL DIRECTOR

ADDRESS

Robert A. Humphrey Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

06140

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY-BETHESDA</u> , MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>8414 QUEEN ANNE'S DR.</u>	
3. NAME OF DECEASED (Type or Print) <u>WILHELMINA</u> (First) <u>H.</u> (Middle) <u>OURAND</u> (Last)		4. DATE OF DEATH <u>JUNE 1</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3-27-85</u> 9. AGE last birthday <u>66</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME - <u>Louis Hartig</u>		14. MOTHER'S MAIDEN NAME <u>Emma Comradis</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. C. H. Ourand</u> <u>6219 Western Ave., Chevy Chase, D. C.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Decomposition

INTERVAL BETWEEN ONSET AND DEATH

1-2 years

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

108

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

(1) Pneumonia, left lobe.

(2) Pleurisy with effusion (left)

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949 to 1 June 51, that I last saw the deceased

alive on 1 June, 1951, and that death occurred at 9:45 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William D. Cend MD

Silver Spring Md

1 June 51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial
DATE REC'D BY LOCAL REG. 6-5-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Bessie M. Thompson
8434 Ga. Ave.
Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JUN 8 1951

RECEIVED

BUREAU V. S.

JUN 8 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Delaware COUNTY New Castle	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elsmere	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 324 New Road	
3. NAME OF DECEASED (First) John (Middle) (n) (Last) PARKS		4. DATE OF DEATH (Month) June 19, (Day) 19 (Year) 51	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 19, 1928
9. AGE last birthday 22 yrs. 10		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Enlisted Man		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Oscar ROBINSON (Foster Parent)		14. MOTHER'S MAIDEN NAME Frances ROBINSON (Foster Parent)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. -----	
17. INFORMANT AND ADDRESS Wife: Naomi PARKS			

18. MEDICAL CERTIFICATION Same as item # 2		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Myocardial Infarction	2 Weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Portal Vein Thrombosis	2 Weeks
	(c) Mesenteric Vein Thrombosis	3 Weeks
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION May 29 1951		19b. MAJOR FINDINGS OF OPERATION Mesenteric Vein Thrombosis with Gangrenous Bowel
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 28**, 19**51**, to **June 19**, 19**51**, that I last saw the deceased alive on **June 19**, 19**51**, and that death occurred at **5:30 A**.m., from the causes and on the date stated above.

SIGNATURE **R. G. Haley** (Degree or title) ADDRESS DATE SIGNED

R. G. HALEY, LTJG, MCR, USNR **U.S. NAVAL HOSPITAL, BETHESDA, MD.** **June 20, 1951**

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF June 20, 1951	NAME OF CEMETERY OR CREMATORY Gracelawn Memorial Park	LOCATION (City, town, or county) (State) Wilmington, Delaware
DATE REC'D BY LOCAL REG. June 20, 1951	REGISTRAR'S SIGNATURE Edith Whittington	24. FUNERAL DIRECTOR ADDRESS Wastler Funeral Home, 301 East Capitol Street, Washington, D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 16

595916

TO

BUREAU U. S.

JUN 25 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06142

Reg. Dist. No. 223

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Mont</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 Sherman Avenue</u>		STREET ADDRESS (If rural give location) <u>17 Sherman Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>EMMA</u> (Middle) <u>HARRIET</u> (Last) <u>PARSHALL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>9</u> <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/2/64</u>
9. AGE last birthday <u>86</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Nathan Jersey</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Thelma Parrish, 17 Sherman Ave. Tak. Pk.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Coronary Thrombosis</u>	<u>1 hour.</u>
Antecedent cause(s)	(b) <u>Coronary artery disease</u>	<u>1 year.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Arteriosclerosis Generalized</u>	<u>10 years.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Apr. 10, 1950, to 9 June, 1951, that I last saw the deceased alive on 9 June, 1951, and that death occurred at 6:55 P.m., from the causes and on the date stated above.

SIGNATURE <u>Dr. Lucien M. R. 7112 Willow Ave Takoma Park Md</u>		ADDRESS <u>9 June 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>June 13, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Chesaning Cemetery</u>	LOCATION (City, town, or county) (State) <u>Chesaning, Michigan</u>
DATE REC'D BY LOCAL REG. <u>6/9/51</u>	REGISTRAR'S SIGNATURE <u>J. Arthur Dalters</u>	24. FUNERAL DIRECTOR <u>J. Arthur Dalters</u>	ADDRESS <u>224 Carroll St. N.W. Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 13 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06143

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12,204 Judson Road</u>		STREET ADDRESS (If rural, give location) <u>12,204 Judson Road</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Walter</u>	<u>Duff</u>	<u>Paterson</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 19, 1887</u>
9. AGE last birthday <u>63</u> yrs.		10. DATE OF DEATH <u>June 10, 1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lincoln Machine Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Glasgow, Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA -1917</u>	
13. FATHER'S NAME <u>Charles Paterson</u>		14. MOTHER'S MAIDEN NAME <u>Ann Patuelo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>037-12-3074</u>	
17. INFORMANT AND ADDRESS <u>Mrs. E. T. McMullen, 12,204 Judson Rd.</u>			

18. MEDICAL CERTIFICATION

Silver Spring, Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Coronary occlusion1 hr.

Antecedent cause(s)

(b)

Cardio-vascular-renal disease3 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/5, 1948, to 6/10, 1951, that I last saw the deceasedalive on 6/10, 1951, and that death occurred at 6:15 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Capt. J. B. Smith M.D.811-8-NE Wash @ O.C.6/11/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Trans. & Burial</u>	<u>6/11/51</u>	<u>Moshassuck Cemetery</u>	<u>Providence County, R. I.</u>

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/11/51Frances PotterWarren B. Humphrey8434 Georgia Ave. Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED
JUN 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06144

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTRY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Town Cabin John Gardens</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Town Cabin John Gardens</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>21 Froude Circle</u>		STREET ADDRESS (If rural, give location) <u>21 Froude Circle</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>EDWARD</u> (Middle) <u>MARION</u> (Last) <u>PATRICK</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8 May 1908</u>
9. AGE last birthday <u>43</u> yrs.		10. If under 1 year: Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect-Mechanical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Europe</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>Edward M. Patrick</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Angel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Henrietta Patrick -Same as Item# 2</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Crownary Thrombosis</u>			<u>1 Hour</u>
Antecedent cause(s) (b) <u>Chronic Hypertension</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 6</u> , 19 <u>51</u> , to <u>June 18</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>51</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. F. Greaney, Jr.</u>		ADDRESS <u>7542 12th Ave Wash DC</u>	
DATE SIGNED <u>June 18, 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/21/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REG. <u>6/19/51</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
FUNERAL DIRECTOR <u>Robert C. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

003916

RECEIVED

JUN 22 1951

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06145

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>3800 14th St. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harriet Emerson</u>	(Middle) <u>Perry</u>	(Last) _____
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify) _____	8. DATE OF BIRTH <u>7-29-80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE last birthday <u>70</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Auburn, Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Roscoe Emerson</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Babcock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. Joseph Perry -</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of Liver

INTERVAL BETWEEN ONSET AND DEATH

2 mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) _____

(c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 15, 1951, to June 24, 1951, that I last saw the deceased alive on June 25, 1951, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/29/51</u>	<u>Cedar Hill Cemetery</u>	<u>Prince Georges Co. Md</u>	<u>D.C.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/26/51</u>	<u>Bessie M. Thompson</u>	<u>H. D. Jones Co.</u>	<u>Washington D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V.S. A12

RECEIVED
JUN 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06146

Reg. Dist. No. 216

CERTIFICATE OF DEATH

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase (Orchardale)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase (Orchardale)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5304 Sherrill Avenue</u>		STREET ADDRESS (If rural give location) <u>5304 Sherrill Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Robert</u>	<u>F.</u>	<u>Perry</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	4. DATE OF DEATH (Month) (Day) (Year)
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>June 7, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH	9. AGE last birthday (If under 1 year Months Days Hours Min.)
<u>Retired Manufacturer</u>	<u>Wood Products</u>	<u>Jan. 19, 1884</u>	<u>67</u> yrs.
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
<u>Mannisten, Michigan</u>	<u>USA</u>	<u>Steven Perry</u>	<u>Mary Hurley</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.	17. INFORMANT	
(If yes, give war or dates of service)		<u>Robert C. Perry, Jr. (son)</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

15 min.

Antecedent cause(s)

(b)

Arterio sclerosis10 + yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Cerebral thrombosis first attack6 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Paralytic bladder3 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Net While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 51, 1951, to June 51, 1951, that I last saw the deceasedalive on 28 May 51, 1951, and that death occurred at 2:55 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-8-51Bessie M. Thompson7 June 51
5522 Western Ave. 7 June 51
Natchez Cemetery Natchez, Mississippi
317 Pa. Ave., S.E.

290307

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06147 223
 21/5

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Saltzman Park</u> TOWN <u>Saltzman Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanatorium</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring P.O.</u> TOWN <u>Silver Spring P.O.</u> STREET ADDRESS <u>New Hampshire Ave. - Extended</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Charles</u> (Middle) <u>Albert</u> (Last) <u>Pryor</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-7-1909</u>
9. AGE last birthday <u>42</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey Pryor</u>		14. MOTHER'S MAIDEN NAME <u>Addie Bosler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Dorothy Pryor - Same - Wife</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Hemorrhage & shock</u>		
Antecedent cause(s) (b) <u>Infection of Superior Vena Cava</u>		
164d <u>Slab wound of chest</u>	(c) <u>Slab wound of chest</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
------------------------	----------------------------------	--

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	PLACE (Home, farm, factory, street, office, etc.) <u>Home</u>	(CITY OR TOWN) <u>Silver Spring P.O. Pr. Geo</u>	(COUNTY) <u>Md</u>	(STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-27-51 9:30 P.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR <u>Slab wound of chest with jamie knife</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

SIGNATURE <u>John M. Maloney M.D. Dep. Med. Exam.</u>		ADDRESS <u>Cherry Hill Hyattsville Md.</u>		DATE SIGNED <u>6-27-51</u>
23. BURIAL, CREMATION, REMOVAL, etc.	DATE THEREOF <u>6/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>Stanton</u>	LOCATION (City, town, or county) <u>(Virginia)</u>	(State) <u></u>
DATE REC'D BY LOCAL REG. <u>28/9/51</u>	REGISTRAR'S SIGNATURE <u>J. Wilder Dadda</u>	24. FUNERAL DIRECTOR <u>F. Gasche</u>	ADDRESS <u>Hyattsville Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

970317



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06148

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. NAVAL HOSPITAL		STREET ADDRESS (If rural, give location) 6608 32nd Place, N.W.	
3. NAME OF DECEASED (Type or Print)	(First) (none)	(Middle) (none)	(Last) QUIGLEY
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH June 19, 1951
9. AGE last birthday 00 yrs.		4. DATE OF DEATH June 19, 1951	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Richard QUIGLEY		14. MOTHER'S MAIDEN NAME Frances LISTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS Father: Richard QUIGLEY			

18. MEDICAL CERTIFICATION

Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Erythema blasticum fetalis (hydrops)** 6 1/2 mo

(b) **Rh incompatibility** Indef.

(c)

Antecedent cause(s)

770.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

161c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **June 19, 1951**, to **June 19, 1951**, that I last saw the deceased alive on **June 19, 1951**, and that death occurred at **6:00 P.m.**, from the causes and on the date stated above.

SIGNATURE **L. M. Harris**

(Degree or title)

ADDRESS

DATE SIGNED

L. M. HARRIS, CAPTAIN, MC, USN U.S. NAVAL HOSPITAL, BETHESDA, MD. June 20, 1951

23. BURIAL CREMATION (Specify) Burial	DATE THEREOF June 20, 1951	NAME OF CEMETERY OR CREMATORY USN Medical School	LOCATION (City, town, or county) Bethesda, Maryland.	(State)
DATE REC'D BY LOCAL REG June 20, 1951	REGISTRAR'S SIGNATURE David Whittington	24. FUNERAL DIRECTOR None	ADDRESS	

226/91 306300

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-J

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06149
214
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>704 Gist Ave.</u>		STREET ADDRESS (If rural, give location) <u>704 Gist Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Beatrice Carrick Rice</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>May 19, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Limerick, Ireland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Carrick</u>		14. MOTHER'S MAIDEN NAME <u>Sarah McLaughlin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mr. George C. Rice, 704 Gist Ave.</u>			

18. MEDICAL CERTIFICATION

Silver Spring, Maryland
INTERVAL BETWEEN ONSET AND DEATH

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Primary Carcinoma of Liver2 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

Apr. 28, 51

19b. MAJOR FINDINGS OF OPERATION

Extensive Carcinoma of Liver

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 19, 1951, to June 7, 1951, that I last saw the deceasedalive on June 4, 1951, and that death occurred at 5:15 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

Burial

DATE THEREOF

6/9/51

NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

LOCATION (City, town, or county)

Prince George County, Md.

(State)

DATE REC'D BY LOCAL REG

7/7/51

REGISTRAR'S SIGNATURE

Francis Lott

24. FUNERAL DIRECTOR

Wm. W. Humphrey

ADDRESS

8434 Ga. Ave.Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 11 1954
BUREAU U. S.

06150

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P. G.</u>	
CITY <u>if outside corporate limits, write RURAL and give nearest town</u> OR <u>Takoma Park</u>		CITY <u>if outside corporate limits, write RURAL and give nearest town</u> OR <u>Silverdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash Hosp + San.</u>		STREET ADDRESS <u>Goodluck Rd.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Thomas</u> (Middle) <u>Charles</u> (Last) <u>Rice</u>		(Month) <u>June</u> (Day) <u>20</u> (Year) <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>4-28-1915</u>
9. AGE last birthday <u>36</u> yrs.		10. IF under 1 year Months <u>-</u> Days <u>-</u> Hours <u>-</u> Mins. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR OCCUPATION <u>own self</u>	
11. BIRTHPLACE (State or foreign country) <u>Hopewell, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Frank Rice</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-01-1955</u>	
17. INFORMANT AND ADDRESS <u>Washington Sanitarium Records</u>		18. MEDICAL CERTIFICATION	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
902.8	Immediate cause	(a) Cerebral laceration & hemorrhage	2 hrs.
1862	Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the <u>underlying cause</u> last	(b) Fracture of skull	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
------------------------	----------------------------------	---

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Building</u>	(CITY OR TOWN) <u>Selma Spring</u>	(COUNTY) <u>Monty</u>	(STATE) <u>Ind</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 20-56 4 P. m.</u>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fall from roof of house</u>			

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE _____ (Degree or title) ADDRESS _____ DATE SIGNED _____

Frank J. Brochant M.C.		Yantherbury Rd		6-21-57
24. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(Date)
Burial	6/23/57	St Lincoln	Columbia Manor Md	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
6-21-57	Amanda Wozney	T. Gachmann	Hyattsville	
6-23-57	J. John Dold Reg		Md 510246	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V8-A15A

BUREAU V. S.

JUN 27 1951

RECEIVED

Item I: Film G154-5/27/53-L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06472

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
TOWN <u>Suburban</u>		TOWN <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural, give location) <u>3207 Fayette Rd.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Winifred</u> <u>Wright</u> <u>Robertson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>26</u> <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>June 1, 1920</u>
9. AGE last birthday <u>31</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Schenectady, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Wright</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cullings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Husband. Same</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) acute gastric distension due to venous thrombosis

Antecedent cause(s)

(b) Mitral Stenosis(c) Polymyositis, Respiratory Muscle Weakness

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Bronchopneumonia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE <u>No</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>No</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 24, 1951, to June 26, 1951, that I last saw the deceasedalive on June 26, 1951, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Chevy Chase, Md.

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial-Transit</u>	<u>6-28-51</u>	<u>Esperence</u>	<u>Esperence, Schenectady, N.Y.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-27-51</u>	<u>Bessie M. Thompson</u>	<u>Robert A. Pumphrey</u>	<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06151

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring		CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 11,126 Old Bladensburg Road		STREET ADDRESS (If rural, give location) 11,126 Old Bladensburg Road	
3. NAME OF DECEASED (Type or Print) William Patrick Ryan		4. DATE OF DEATH June 27 19 51	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 7, 1898
9. AGE last birthday 53 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Boston, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David J. Ryan		14. MOTHER'S MAIDEN NAME Noah Clifton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1 day		16. SOCIAL SECURITY NO.	
17. INFORMANT Silver Spring, Maryland		18. Mrs. Kathleen Ryan, 11,126 Old Bladensburg Rd.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(a) *Asphyxia due to carbon*
(b) *monoxide poisoning*
(c)

INTERVAL BETWEEN ONSET AND DEATH

Interval
dead in
auto in
garage

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.PLACE (Home, farm, factory, street, office hldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

Rose extending from exhaust thru car window

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/28/51

Francis Potter

Warner B. Humphrey

8434 Georgia Ave.

Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

270674

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06152

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>605 Rolling Rd.</u>		STREET ADDRESS (If rural, give location) <u>605 Rolling Rd.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>McCLEAREY HOBBS SANBORN Sr.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 2, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8 Feb. 1893</u>
9. AGE last birthday <u>58</u> yrs.		10. If under 1 year (Month) (Day) (Hour) (Min.) <u>3 24</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Engineer-Mechanical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sugar Plantation</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thornton F. Sanborn</u>		14. MOTHER'S MAIDEN NAME <u>Cora B. McClearey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Rosa P. Sanborn-Same as Item #2</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

199.1

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

53

(a)

Cancer of left ear

(b)

& Cerebral Metastases

(c)

INTERVAL BETWEEN ONSET AND DEATH

25 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-31, 1951, to 6-2, 1951, that I last saw the deceased

alive on 6-2, 1951, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. F. Royce M.D. Bethesda, Md.

6-3-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Cremation
DATE REC'D BY LOCAL REG.
6/4/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Bessie M. Thompson

Robert W. Humphrey Bethesda, Md.

046105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A75/

RECEIVED
JUN 6 1951
BUREAU V. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8707 Grant St.</u>		STREET ADDRESS (If rural, give location) <u>8707 Grant</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Thurston</u> (Middle) <u>C</u> (Last) <u>Saul</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>23</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/7/1905</u>
9. AGE last birthday <u>45</u> yrs. <u>11</u> months <u>16</u> days		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Washington Gas Works Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Sorrell</u>		14. MOTHER'S MAIDEN NAME <u>May Weedon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>8707 Grant St.,</u>		17. INFORMANT AND ADDRESS <u>Elsie B. Saul Bethesda, Md.,</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Thoracic hemorrhage due to</u>			<u>sudden death</u>
Antecedent cause(s) (b) <u>bullet wound in chest</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>164c</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg, etc.) <u>Home</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 23, '51 2:40 m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>self-inflicted</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Bruschak M.D.</u>		DATE SIGNED <u>6-23-57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/25/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		LOCATION (City, town, or county) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REG. <u>6/26/51</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213-

06154

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>420 GREENBRIER DR.</u>	
TOWN <u>TAKOMA PARK</u> 3 yrs.		TOWN <u>TAKOMA PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 PHILADELPHIA AVE</u>		STREET ADDRESS <u>TAKOMA PARK</u>	
3. NAME OF DECEASED (First) <u>Mrs. Lila</u> (Middle) <u>Scatterday</u> (Last) <u>Scatterday</u>		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG 26, 1878</u>
9. AGE last birthday <u>72</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>NELSONVILLE, OHIO</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>WM. ALDRIDGE WORLEY</u>	14. MOTHER'S MAIDEN NAME <u>ADALINE REEDER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY No. <u>NONE</u>	17. INFORMANT AND ADDRESS <u>MRS. HELEN M. CLELLAN TAK. PK. MD.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

592X Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

20 days
Indefinite

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 25, 1951, to June 14, 1951, that I last saw the deceased alive on June 14, 1951, and that death occurred at 11:55 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL - TAKOMA PARK</u>	DATE THEREOF <u>6/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>COLUMBUS</u>	LOCATION (City, town, or county) <u>OHIO</u>	(State)
DATE REC'D BY LOCAL REG. <u>6/15/51</u>	REGISTRAR'S SIGNATURE <u>William D. Dadd</u>	24. FUNERAL DIRECTOR <u>Robert A. Doughty</u>	ADDRESS <u>Bethesda Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-5 T

RECEIVED

JUN 20 1934

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

06155

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium and Hospital</u>		STREET ADDRESS (If rural, give location) <u>5700 16th St. N.W.</u>	
3. NAME OF DECEASED (Type or Print) First <u>Neshan</u> Middle <u>Shamigian</u> Last <u>Shamigian</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 28, 1894</u>
9. AGE last birthday <u>60</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Restaurant Hotel</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Palou, Armenia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>Garabed Shamigian</u>	14. MOTHER'S MAIDEN NAME <u>Anna Kenzoian</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Hospital records</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

General Carcinomatosis - E. Abassera

INTERVAL BETWEEN ONSET AND DEATH
14 mo.

Antecedent cause(s)

(b)

Carcinoma of Left Colon

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Carcinoma of Left Colon c Metastasis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

April 19, 50

19b. MAJOR FINDINGS OF OPERATION

Carcinoma of Colon c Metastasis

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office block, etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1951, to June, 1951, that I last saw the deceased

alive on June 16, 1951, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William J. B. Orr, M.D. 1835 - E. H. Washington JUN 19 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-17-51

William J. B. Orr

The S. H. Hines Co. 2901-14th St. N.W.

Washington, D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 20 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06156

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Silver Spring</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>2220 - Washington Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>David</u> (Middle) <u>Shapiro</u> (Last) <u>Shapiro</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>23 June 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>70</u> yrs. If under 1 year Months. Days Hours Min.
13. FATHER'S NAME <u>Yale</u>		14. MOTHER'S MAIDEN NAME <u>SAPA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		17. INFORMANT <u>Wife, Lena Shapiro</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Respiratory failure</u>				<u>3 wks</u>	
420.1 Antecedent cause(s) (b) <u>Myocardial infarction</u>				<u>4 wks</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Renal insufficiency, chronic</u>				<u>25 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>31 Dec.</u> , 19 <u>50</u> , to <u>4 June</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4 June</u> , 19 <u>51</u> , and that death occurred at <u>10:05 P.</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Milton Luback, M.D.</u>		ADDRESS <u>108 - E. Melbourne Ave., Silver Spring Md.</u>		DATE SIGNED <u>4 June 51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE <u>6/6/51</u>		NAME OF CEMETERY OR CREMATORY <u>King Solomon Cemetery</u>	
LOCATION (City, town, or county) <u>Clifton, New Jersey</u>		(State) <u>New Jersey</u>		24. FUNERAL DIRECTOR <u>B. Damiansky & Son</u>	
DATE REC'D BY LOCAL REG. <u>6/5/51</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		ADDRESS <u>3501 - Rd 075868 St. N.W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06157

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH— COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lubbers Hospital</u>		STREET ADDRESS (If rural, give location) <u>8302 M. de C. Highway Blvd.</u>	
3. NAME OF DECEASED (First) <u>Charles</u> (Middle) <u>T</u> (Last) <u>SHAW</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 2, 1895</u>
9. AGE last birthday <u>56</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Clear Spring, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Cond. Engineer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. Charles Shaw</u>		14. MOTHER'S MAIDEN NAME <u>Emathia Decal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>577-09-5797</u>	
17. INFORMANT AND ADDRESS <u>Ruth V. Shaw— Same as item #2</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Pulmonary Edema</u>		<u>2 mos.</u>	
Antecedent cause(s) (b) <u>Myocardial Infarction</u>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 1, 1951</u> , to <u>June 7, 1951</u> , that I last saw the deceased alive on <u>June 7, 1951</u> , and that death occurred at <u>12:05 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>William M. Gadel</u>		DATE SIGNED <u>6/7/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>6-7-51</u>		24. FUNERAL DIRECTOR <u>Robert A. Thompson</u>	
REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS-151

Med. examiner notified and approved.

William N. Gadol - MD

BUREAU V. S.

JUN 11 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06158

Reg. Dist. No. 218

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> TOWN <u>life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> TOWN <u>life</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>James</u> (First) <u>Sidney</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>June 24</u> (Month) <u>1951</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 19, 1889</u>
9. AGE last birthday <u>62</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Louis Sidney</u>		14. MOTHER'S MAIDEN NAME <u>Jane Coland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Sadie Moore</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Thoracic hemorrhage due to</u>	INTERVAL BETWEEN ONSET AND DEATH <u>within</u>
Antecedent cause(s) (b) <u>Crushed chest (rt.)</u>	<u>death</u>
(c) <u>812.5 170c</u>	

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office, etc.) OF INJURY <u>Highway</u>	(CITY OR TOWN) <u>Germantown R.T.D.</u> (COUNTY) <u>Montg</u> (STATE) <u>md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 24-51-11:05</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Struck by auto</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) Frank J. Brochert M.D. ADDRESS Frederick md DATE SIGNED 6-25-51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>St Rose</u>	LOCATION (City, town, or county) <u>Blowing Rock, md</u> (State) <u>md</u>
DATE REC'D BY LOCAL REG. <u>June 27, 1951</u>	REGISTRAR'S SIGNATURE <u>Abundia L. Cooke</u>	24. FUNERAL DIRECTOR'S ADDRESS <u>Robert L. Snowden Rockville, md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A154

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06159

Reg. Dist. No. 216

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>North Chevy Chase</u> LENGTH OF STAY (In this place) <u>3 yrs</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>North Chevy Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>25 LeVelle Drive</u>				STREET ADDRESS (If rural, give location) <u>25 LeVelle Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Burrell</u> (First)		(Middle) <u>A.</u>		(Last) <u>Sloan</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 31 1908</u>	
9. AGE last birthday <u>42</u> yrs.		If under 1 year Months <u>10</u> Days <u>16</u>		If under 24 hours Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Conn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Adrian Boyd Sloan</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hatch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or date of service) <u>W.W. 2</u>				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Margaret H. Sloan</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Calcific valvular aortic stenosis</u>						<u>sudden death</u>	
Antecedent cause(s) (b) <u></u>							
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschack M.D.</u>				DATE SIGNED <u>6-17-51</u>			
(Degree or title)				ADDRESS <u>Yarthurburg Md</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>6/18/51</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		LOCATION (City, town, or county) (State) <u>Surtland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>6/18/51</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md</u>	

VS. A15A

075869

RECEIVED

JUN 20 1951

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06160

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Luburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>5501 Huntington Pkwy.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u> (Middle) <u>Earl</u> (Last) <u>Smith</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 24 1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>7-23-1897</u>
9. AGE last birthday <u>53</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Smith</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Boweers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-05-8510</u>	
17. INFORMANT AND ADDRESS <u>H. Davis Smith Same as item #2</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral hemorrhage - massive

INTERVAL BETWEEN ONSET AND DEATH

5 hrs -

Antecedent cause(s)

(b) Hypertension -10 yrs -

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) old l. hemiplegia3 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1946, to June, 1950; that I last saw the deceasedalive on May 20, 1951, and that death occurred at 3:45 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) <u>Suitland, Md.</u>	(State) <u>Bethesda</u>
DATE REC'D BY LOCAL REG. <u>6/26/51</u>	REGISTRAR'S SIGNATURE <u>Bessie D. Thompson</u>	M. FUNERAL DIRECTOR <u>Robert H. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

690478

Donovan
8/16

RECEIVED
JUN 28 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06161
215
Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>2614 Woodley Place, N.W.</u>	
3. NAME OF DECEASED (First) <u>George</u>	(Middle) <u>Leonard</u>	(Last) <u>SMITH</u>	4. DATE OF DEATH (Month) <u>June 14,</u> (Day) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 30, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	9. AGE last birthday <u>74 yrs.</u> <u>09</u> months <u>14</u> days
11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Charles E. SMITH</u>		14. MOTHER'S MAIDEN NAME <u>Arabella DOW</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>SPAM., WW I & II</u>	
17. INFORMANT AND ADDRESS <u>Wife: Braden "Bradie" SMITH</u>			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) CARCINOMA OF CECUM WITH METASTASES

Antecedent cause(s)

(b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause lastII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 2, 1951, to June 14, 1951, that I last saw the deceased alive on June 14, 1951, and that death occurred at 4:13 P.m., from the causes and on the date stated above.

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June 18, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	LOCATION (City, town, or county) <u>Arlington, Virginia</u>	(State)
DATE REC'D BY LOCAL REG <u>June 15, 1951</u>		REGISTRAR'S SIGNATURE <u>Elmer W. Hittington</u>		24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, 1756 Pennsylvania Avenue, NW, Washington, D. C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

290716

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06162

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Virginia</u> COUNTY	
CITY (If outside corporate limits, write OR give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write OR give nearest town) <u>Arlington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium</u>		STREET ADDRESS (If rural, give location) <u>2313 No. Quantico St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Elizabeth</u> (Middle) <u>Smith</u> (Last) <u>Thompson</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>5</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-24-76</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
13. FATHER'S NAME <u>unk.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs Howard Falls church 8663</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pelvic peritonitis

Antecedent cause(s) (b) Intestinal obstruction

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) granulosa cell tumor, invasion of wall of rectum

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>granulosa cell tumor of ovary.</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION <u>May 23, 57</u>	19b. MAJOR FINDINGS OF OPERATION <u>Int. obstruction of recto sigmoid junction</u>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May 20, 1957, to June 5, 1957, that I last saw the deceased alive on June 5, 1957, and that death occurred at 3:42 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

RECEIVED
JUN 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06163

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sandy Spring		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sandy Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Harry S. Stansbury		4. DATE OF DEATH June 3, 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 23, 1877
9. AGE last birthday 73 yrs.		10. If under 1 year: Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - retired		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Howard Stansbury		14. MOTHER'S MAIDEN NAME Elizabeth Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Mr. Kenelm Dallam Sandy Spring, Maryland			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Uræmia**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Chronic Interstitial Nephritis**(c) **Renal Arterio Sclerosis**

INTERVAL BETWEEN ONSET AND DEATH

2 days**4 yrs****"**II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) C	PLACE (Home, farm, factory, street, OF office hldg., etc.) C	(CITY OR TOWN) C	(COUNTY) C	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY C	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? C		

22. I hereby certify that I attended the deceased from **10/11**, 19**50**, to **6/3**, 19**51**, that I last saw the deceased alive on **6/3**, 19**51**, and that death occurred at **5:20 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6/5/51	NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	LOCATION (City, town, or county) Baltimore County	(State) Md.
DATE REC'D BY LOCAL REG. 6-4-51	REGISTRAR'S SIGNATURE Berlinde B. Lander	24. FUNERAL DIRECTOR Warner & Pumphrey	ADDRESS 8434 Ga. Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

RECEIVED
JUN 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Olney</u> LENGTH OF STAY (in this place) <u>20 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gaithersburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery Co. Gen Hosp</u>		STREET ADDRESS (If rural, give location) <u>Route 3</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>LEANA</u> (Middle) <u>Stevenson</u> (Last) <u>Stevenson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 16 1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 2, 1897</u>
9. AGE last birthday <u>54</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David D. Diggs</u>		14. MOTHER'S MAIDEN NAME <u>Jemima Wallace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Wm. Stevenson - Gaithersburg Md.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Hypertension

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arthritis

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/25, 1951, to 6/16, 1951, that I last saw the deceased

alive on 6/15, 1951, and that death occurred at 8:35 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 6-20-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED
JUN 25 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06165 21.3

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>203 England Terrace</u>		STREET ADDRESS (If rural, give location) <u>203 England Terrace</u>	
3. NAME OF DECEASED (First) <u>S.</u> (Middle) <u>Alice</u> (Last) <u>Suddath</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-23-1905</u>
9. AGE last birthday <u>45 6</u> yrs. If under 1 year Months <u>5</u> Days <u>14</u> If under 24 hrs. Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Francis E. Davis</u>	
14. MOTHER'S MAIDEN NAME <u>Lulu H. Hager</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>219-12-6520</u>		17. INFORMANT AND ADDRESS <u>William E. Suddath-husband-Same as /</u> Item 2	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Carcinoma of uterine cervix, with1 1/2 years

Antecedent cause(s)

(b) generalized metastasis.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none.

19a. DATE OF OPERATION <u>July 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Biopsy, followed by radiation (Dr. Arch Reddish)</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>		PLACE (Home, (arm, factory, street, office bldg, etc.) <u></u>		(CITY OR TOWN) <u>Rockville, Md.</u> (COUNTY) <u>Montgomery</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>		INJURY OCCURRED While at Work <input type="checkbox"/> No While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u></u>	

22. I hereby certify that I attended the deceased from March, 1950, to June 17, 1951, that I last saw the deceased alive on June 17, 1951, and that death occurred at 2:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION (Specify) <u>Burial</u>		DATE THEREOF <u>6-20-1951</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Methodist</u>		LOCATION (City, town, or county) <u>Montgomery</u>		(State) <u>Maryland</u>	
DATE REC'D BY LOCAL REG. <u>6-19-51</u>		REGISTRAR'S SIGNATURE <u>Alexander A. Chisfalter</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphreys</u>		ADDRESS <u>Bethesda, Md</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 21 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06166

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write nearest town) <u>Lakema Park</u>		CITY (If outside corporate limits, write nearest town) <u>Silver Spring</u>	
TOWN <u>Lakema Park</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. & Hospital</u>		STREET ADDRESS (If rural, give location) <u>7 Park Valley Road</u>	
3. NAME OF DECEASED (First) <u>Alice</u> (Middle) <u>Lee</u> (Last) <u>Summers</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>9-24-34</u>	
9. AGE last birthday <u>16</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. Summers</u>		14. MOTHER'S MAIDEN NAME <u>Geraldine C. Holbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>William Summers, 7 Park Valley Rd. Ss. Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

204.0 Immediate cause
74a Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Recurrent Hemorrhage
(b) Acute Lymphatic Leukemia
(c)

INTERVAL BETWEEN ONSET AND DEATH

9 hours
3 weeks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 21, 1951, to June 11, 1951, that I last saw the deceased alive on June 11, 1951, and that death occurred at 5:35 P.m., from the causes and on the date stated above.

SIGNATURE [Signature] (Degree or title)

ADDRESS 1833 - Monroe St. N.E. Wash. D.C. 4/5-1 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
DATE REC'D BY LOCAL REG. <u>6-13-51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>	ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 - 1961
BOSTON U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06167
Reg. Dist. No. 223

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lakoma Park,</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. San. & Hospital</u>		STREET ADDRESS (If rural, give location) <u>632 Ritchie Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ella</u> (Middle) <u>T.</u> (Last) <u>Van Horn</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 17</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/11/1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>52</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George S. Weber</u>		14. MOTHER'S MAIDEN NAME <u>Anne T. Murphy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Elsie O'Roark, 632 Ritchie Ave.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause		(a) <u>Rheumatic heart disease with Aortic Stenosis,</u>	
Antecedent cause(s)		(b) <u>Mitral Stenosis and Insufficiency</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>51</u> , to <u>June 17</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>51</u> , and that death occurred at <u>3:00 Pm</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Aaron H. Trautman</u>		ADDRESS <u>M.D. 8237 Georgia Ave Silver Spring Md</u>	
DATE SIGNED <u>June 17, 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>6/20/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Prince George County Md.</u>
DATE REC'D BY LOCAL REG. <u>6-19-51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u> ADDRESS <u>8434 Ga. Ave. Silver Spring, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

BUREAU V. S.

JUN 22 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06168

Reg. Dist. No. 516

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine View Rest Home</u>		STREET ADDRESS (If rural, give location) <u>Pine View Rest Home</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Maud</u>	(Middle) <u>Getty</u>	(Last) <u>Walsh</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6 10 1862</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XXXX</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
13. FATHER'S NAME <u>George W. Getty</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Stevenson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Orville E. Walsh-Portland, Oregon</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Chronic Salivary heart disease4 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic arthritis - & hypertension4 yrs.11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-12-51Beaie M. ThompsonRobert A. ThompsonBethesda, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

RECEIVED
JUN 15 1951
BUREAU V. S.

Reg. Dist. No. 443

Reg. Dist. No. 443

Reg. Dist. No. 443

1. PLACE OF DEATH. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lakema Park</u>		LENGTH OF STAY (in this place) <u>13 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lakema Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. & Hospital</u>				STREET ADDRESS <u>909 Greenwood Ave</u>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Anna</u>		(First)		(Middle) <u>M</u>		(Last) <u>Washer</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		4. DATE OF DEATH <u>6</u> <u>1</u> <u>1951</u>	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		4. DATE OF DEATH	
<u>Female</u>		<u>white</u>		<u>Divorced</u>		<u>6</u> <u>1</u> <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		8. DATE OF BIRTH <u>12-9-78</u>		9. AGE last birthday <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE last birthday	
<u>Housewife</u>		<u>Home</u>		<u>12-9-78</u>		<u>72</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Ritsenour</u>		14. MOTHER'S MAIDEN NAME <u>Minnic F. Hedrick</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. (If yes, give war or dates of service)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
<u>No</u>				<u>No</u>			
17. INFORMANT AND ADDRESS <u>Mrs. Mary Taylor 909 Greenwood Ave.</u>				17. INFORMANT AND ADDRESS			
<u>Mrs. Mary Taylor 909 Greenwood Ave.</u>							

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <i>Uremia</i>								<i>weeks</i>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <i>Hypertensive and arteriosclerotic heart disease</i>									
		(c) <i>Chronic nephrosclerosis</i>								<i>years</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.											
<i>Terminal bronchopneumonia</i>											
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from Sept 8, 1976, to June 1, 1987, that I last saw the deceased alive on June 1, 1987, and that death occurred at 6:40 P.m., from the causes and on the date stated above.

<u>1</u> SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
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(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)				DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial				June 4, 1951	Ft. Lincoln Cemetery	Baltimore	Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS		
6-1-51	F. M. Deak		Arthur Walters		254 Carroll St.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JUN 4 1961

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH.

06170

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
TOWN <u>Frederick</u>		TOWN <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Washington Grove Ind</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ARTHUR</u> (Middle) <u>REESE</u> (Last) <u>WATKINS</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept 3 1873</u>
9. AGE last birthday <u>77</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11a. USUAL OCCUPATION (Give kind of work and during most of working life, even if retired) <u>Government Clerk</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Watkins</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Boker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Ellie E Watkins</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Uremia10 days

Antecedent cause(s)

(b)

Hypertensive - cardiovascularUnknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Renal diseaseUnknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Benign HypertrophyUnknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to June 2, 1951, that I last saw the deceasedalive on June 1, 1951, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 41

RECEIVED
JUN 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06171

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY Montgomery CITY (If outside corporate limits, write RURAL and OR give nearest town) Silver Spring TOWN Silver Spring HOSPITAL OR INSTITUTION OR STREET ADDRESS 9305 Mintwood Place		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring TOWN Silver Spring STREET ADDRESS (If rural, give location) 9305 Mintwood Place	
3. NAME OF DECEASED (Type or Print) Mary Neale Welling		4. DATE OF DEATH (Month) June (Day) 23 (Year) 19 51	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 11/24/63
9. AGE last birthday 87 yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Own home	
12. BIRTHPLACE (State or foreign country) Highland, Maryland		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME Pressley Schooley		15. MOTHER'S MAIDEN NAME Jame Adams	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY No. none	
18. INFORMANT Mrs. Cuyler McNeil		19. ADDRESS 9305 Mintwood Place, Silver Spring, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Cerebral hemorrhage due to

Antecedent cause(s)

(b)

fracture of skull

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.PLACE (Home, farm, factory, street, OF office bldg., etc.) **Home**
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY **Jun 23-51-12:30** m.INJURY OCCURRED While at work ☐ Nnt while et work ☒

HOW DID INJURY OCCUR?

*Fell on floor of his bed room*22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial**6/25/51****St. Mark's Cemetery****Highland, Md****Md.****6/25/51****Frances Potter****Warner B. Humphrey, 8434 Ga. Ave.****Silver Spring, Maryland**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

JUN 27 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

06172

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2604 Sheraton Street</u>		STREET ADDRESS (If rural, give location) <u>2604 Sheraton Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Hannah</u>	(Middle) <u>A.</u>	(Last) <u>Welsh</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>24</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 1, 1871</u>
9. AGE last birthday <u>80</u> yrs.	If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lansford, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Boyle</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Boyel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>----</u>	
17. INFORMANT AND ADDRESS <u>Mr. James Welsh, 2604 Sheraton St.</u>			
18. MEDICAL CERTIFICATION <u>Silver Spring, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinomatous</u>			<u>3 months</u>
Antecedent cause(s) (b) <u>Paget's Disease left Breast</u>			<u>2 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u> </u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 24, 1951</u> , to <u>June 24, 1951</u> , that I last saw the deceased alive on <u>June 24, 1951</u> , and that death occurred at <u>10:55 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Glenn P. Pincus, Md.</u>		ADDRESS <u>4000-16 St. N.W.</u>	
DATE SIGNED <u>June 24, 1951</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans. & Burial</u>	DATE THEREOF <u>6/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>	LOCATION (City, town, or county) (State) <u>Summit Hill, Carbon Co. Pa.</u>
DATE REC'D BY LOCAL REG. <u>6/25/51</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>	
		ADDRESS <u>8434 Georgia Ave. Silver Spring, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Note - I am substituting for Dr
Wm J Lockett of Wash, D.C. while he
is on vacation. Dr Lockett reported
her condition to me before leaving
town and had been attending her for
past five months.

Wm Pincock M.D.

Dr Branchat ratified & approved.

BUREAU V. S.

JUN 27 1951

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County MONTGOMERYCity or town FARMER PARK SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

805 Juniper St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 805 Juniper St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

RUBIN WEXLER

3.(b) Social Security Number

UNK.

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

B.(b) Name of husband or wife

ADELE

7. Birth date of deceased (mo., day, yr.)

MAR 17, 18786.(c) If alive, give age 68 years

8. AGE:

Years

73

Months

2

Days

28

If less than one day

hrs.min.

9. Birthplace

ROMANIA

(Town, county, and state)

10. Usual occupation

RET.

11. Industry or business

MOTHER FATHER

12. Name

ISAAC WEXLER

13. Birthplace

ROMANIA

14. Maiden name

15. Birthplace

16. Informant

MISS HILDA WEXLER

Address

805 JUNIPER

17.

BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

JUNE 17-1951

(month) (day) (year)

Cemetery or crematory

MT. LEBANON CEM.

Location

RIGGS RD.

18. Funeral director

GOLDBERG FUN. HOME

Address

4217- 9th St. N.W., Wash., D.C.

19.

6/15/51

(Date rec'd by registrar)

19.

Francis Potter

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1951 at 10:00 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1951 to June 14 1951and that I last saw him alive on June 12 1951Immediate cause of death Carcinoma of colon with metastasis throughout abdomen

DURATION

5 years

Due to

Due to

Other conditions Diabetes mellitus153X46 (Include pregnancy within 8 months of death)Major findings of operations Carcinoma of colonDate of op. Jan 14 + Mar 51Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lewis M. Bendett, M.D.

M.D. or other

Address 1801 EYE ST. N.W. Wash. D.C. Date signed 6/15/51

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06174

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Silver Spring</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFJ #2 Silver Spring Md.</u>		STREET ADDRESS (If rural, give location) <u>RFJ #2</u>	
3. NAME OF DECEASED (Type or Print) <u>FLORENCE</u> (First) <u>MILGREN</u> (Middle) <u>WHITE</u> (Last)		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SEPARATED</u>	8. DATE OF BIRTH <u>Aug 8 1890</u>
9. AGE last birthday <u>60</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>HOPKINS</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Florence Nichols RFJ #2 Silver Spring Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusions

Antecedent cause(s)

(b) Arteriosclerotic - Hypertensive Cerebrovascular Disease

(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

48 hrs.10 yrs.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June, 1949, to June 7, 1951, that I last saw the deceasedalive on June 6, 1951, and that death occurred at 12 A.m., from the causes and on the date stated above.SIGNATURE George P. George (Degree or title) M.D. ADDRESS 8055 13th St. Silver Spring Md DATE SIGNED June 7, 1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/8/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) <u>Prince George</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>6/7/51</u>	REGISTRAR'S SIGNATURE <u>Stanley Potter</u>	24. FUNERAL DIRECTOR <u>Walter B. Humphrey</u>	ADDRESS <u>8434 Georgia Ave. Silver Spring, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

RECEIVED
JUN 11 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06175

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TAKOMA PARK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TAKOMA PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>905 MAPLE AVE</u>		STREET ADDRESS (If rural, give location) <u>905 MAPLE AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GEORGE</u>	(Middle) <u>EDWARD</u>	(Last) <u>WHITE</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 18, 1898.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GASOLINE SERVICE STATION OWNER - OWN BUSINESS</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>53</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>WILMINGTON, DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE EDWARD WHITE</u>		14. MOTHER'S MAIDEN NAME <u>LUCY ROGER.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>MRS MARION E. WHITE, 905 MAPLE AVE, TAK.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Lymphosarcoma

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

None I know of

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Malnutrition, wasting, etc.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY 0 m.INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1946, to June 21, 1951, that I last saw the deceasedalive on June 21, 1951, and that death occurred at 705 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Chas W. Holohan, M.D.500 Underwood St. NW6/21/5123. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG. 6-21-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BURIALJUNE 24, 1951GEORGE WASHINGTON CEM.RIGGS ROAD, HYATTSVILLE, PRGED Co. Md.6-21-51John W. HolohanArthur Holohan, 254 Cornell St. N.W.605 605 Takoma Park 12, D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 27 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06176

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>3338 Reservoir Road, N.W.</u>	
3. NAME OF DECEASED (First) <u>Homer</u> (Middle) <u>Chapin</u> (Last) <u>WICK</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 5, 1889</u>
9. AGE last birthday <u>61</u> yrs.		10. If under 1 year Months <u>11</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph R. WICK</u>		14. MOTHER'S MAIDEN NAME <u>Alice WOOLCOTT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW 1 & II</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Wife: Mary E. WICK</u>			

18. MEDICAL CERTIFICATION		Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>420.0 Infection, Myocardium</u>		<u>8 hours</u>	
(b) Antecedent cause(s) <u>93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> <u>Arteriosclerotic Heart Disease</u>		<u>15 yrs</u>	
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 15, 1951, to June 15, 1951, that I last saw the deceased alive on June 15, 1951, and that death occurred at 4:10 P.m., from the causes and on the date stated above.

SIGNATURE C. P. Root (Degree or title) ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD. DATE SIGNED June 16, 1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 19, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
DATE REC'D BY LOCAL REG. <u>June 16, 1951</u>	REGISTRAR'S SIGNATURE <u>Edith Whittington</u>	24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, 1756 Pennsylvania Avenue, NW, Washington, D.C.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06178

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Newborn</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS <u>1230 Tidler Lane</u>	
3. NAME OF DECEASED (First) <u>Baby Girl</u> (Middle) <u>Williams</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>—</u>	8. DATE OF BIRTH <u>June 1, 1951</u>
9. AGE last birthday <u>3</u> yrs. If under 1 year Months <u>3</u> Days <u>35</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nathaniel Gerald Williams</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Augustus Bean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Suburban Hospital</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Premature

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Premature(c) none

INTERVAL BETWEEN ONSET AND DEATH

1 hour 2 hours11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6/2/51, 19....., to 6/2/51, 19....., that I last saw the deceasedalive on 6/2/51, 19....., and that death occurred at 12:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Patrick C. Jameson M.D. 11602 Ga Ave Wheaton, Md 6/2/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4 June 1951</u>	<u>Family Cemetery</u>	<u>Montgomery Co., Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/4/51</u>	<u>Bennie M. Thompson</u>	<u>Robert G. Humphrey</u>	<u>Bethesda, Md.</u>	

206011 309240

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

2nd Twin.

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
TOWN <u>Bethesda</u>		TOWN <u>SILVER SPRING</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital 8600 Oakbridge Ln. Rd.</u>		STREET ADDRESS (If rural, give location) <u>2711 SHERDON STREET</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>BABy</u>	(Middle) <u>BoY</u>	(Last) <u>WILKINSON</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>unborn</u>	8. DATE OF BIRTH <u>JUNE 14, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday — yrs. <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS ARTHUR WILKINSON</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ROBERTA WOOLRIDGE</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Ne.</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>MOTHER - 2711 SHERDON ST. SILVER SPRING</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Premature separation of Placenta</u>	<u>2 months</u>
Antecedent cause(s) (b) <u>Premature Separation of Placenta</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on June 14, 1951, and that death occurred at 12:20 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>6/20/51</u>	<u>Suburban Hospital</u>	<u>Bethesda</u>	<u>MD.</u>	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6/22/51</u>	<u>Bessie M. Thompson</u>	<u>Amelia S. Mearns</u>	<u>Supt. Bethesda</u>

216141283150

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 25 1964

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06179

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Spencerville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Spencerville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>Ann</u>	(Last) <u>Wilson</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>24</u>	(Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 3, 1872</u>
9. AGE last birthday <u>79</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Burtonville, Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Calah Carr</u>		14. MOTHER'S MAIDEN NAME <u>Emily Burton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Edward S. Wilson, Highland, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Bacterial Pneumonia

Antecedent cause(s)

(b)

Influenza

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/23/1951 to 6/24/1951 that I last saw the deceasedalive on 6/24/1951, and that death occurred at 12:20 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-25-51Bertine B. Lawlerde Witt Donalson, Laurel, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06180

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Potomac		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chevy Chase	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine View Rest Home		STREET ADDRESS (If rural, give location) 9 Virgilia Street	
3. NAME OF DECEASED (Type or Print) ELLA	(First) MAY	(Middle) WINTER	(Last)
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 16 Nov 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - U.S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Veterans Admr.	9. AGE last birthday 79 yrs.
13. FATHER'S NAME William Winter		14. MOTHER'S MAIDEN NAME Elizabeth Summer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Violet E. Winter Chevy Chase, Md.		12. CITIZEN OF WHAT COUNTRY? USA	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Carcinoma stomach			1 yr.
Antecedent cause(s) (b) Generalized arteriosclerosis			10+ yr.
(c) Right hemiplegia			3 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Terminal Bronchopneumonia			10 days
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) Potomac	(COUNTY) Montgomery
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at **9:25 A.M.**, from the causes and on the date stated above.

SIGNATURE (Degree or title) **ADDRESS** **DATE SIGNED**

Charles Thompson MD **1746-K St NW. Wash DC.** **10 June 51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 6/13/51	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown, Maryland
DATE REC'D BY LOCAL REG. 6/11-51	REGISTRAR'S SIGNATURE Bessie M. Thompson	24. FUNERAL DIRECTOR Robert A. Pumphrey-Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15.

290216

10 June 1951

Dr. Edward Nicklos, Shawmut apt., 19th and Columbia Rd. N.W. Wash. D.C. has cared for Miss Winter. He has seen very recently, and when he left for AMA at Atlantic City, he told me she was critical and would die before his return — he gave me the diagnosis.

I had seen the deceased for Dr. Nicklos at 9 Virginia St. shortly after her right hemiplegia about 3 years ago.

The body was emaciated and an abdominal mass was palpable. I feel certain there are no coroner's questions about this case.

Charles Thompson M.D.

Coroner Notified and approved.

RECEIVED
JUN 14 1951
BUREAU V. S.